

# What Next for Kentucky Health Care?

By  
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and F. Douglas Scutchfield



THE KENTUCKY LONG-TERM POLICY RESEARCH CENTER

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# Preface

This report is the product of a collaborative effort of the Kentucky Long-Term Policy Research Center and the University of Kentucky Center for Health Services Management and Research. *What Next for Kentucky Health Care?* continues to advance the distinct but highly compatible missions of these research centers to inform the policymaking arena and serve as catalysts for change.

Here, we focus on the growing problem of access to health care. The report examines national and state trends that are affecting access to health care, analyzes the difficult course of reform Kentucky has taken, and offers perspectives from state leaders in health care. Further, we examine some model state and community initiatives that have successfully closed gaps in access to health care and conclude with policy recommendations. This report should be of interest to policymakers and citizens alike who are concerned about the issue of access to health care in Kentucky.

## THE KENTUCKY LONG-TERM POLICY RESEARCH CENTER

The Kentucky Long-Term Policy Research Center was created by the General Assembly in 1992 to bring a broader context to the decisionmaking process. The Center's mission is to illuminate the long-range implications of current policies, emerging issues, and trends influencing the Commonwealth's future. The Center has a responsibility to identify and study issues of long-term significance to the Commonwealth and to serve as a mechanism for coordinating resources and groups to focus on long-term planning. Michael T. Childress serves as Executive Director of the Center.

## *The Center for Health Services Management and Research*

The University of Kentucky Center for Health Services Management and Research is an internationally renowned Center of Excellence that informs health policy, influences health systems and ultimately improves the health of individuals and populations. The Center for Health Services Management and Research provides research, consultation, and education in health systems to improve the health of individuals and populations in the Commonwealth and beyond. Its primary goals are: to develop a nationally recognized research program focused on improving access to, and the use, costs, quality, accessibility, delivery, organization, financing, and outcomes of health care services; to improve knowledge and understanding about the structure, processes, and effects of health services for individuals and populations; to provide an independent source of health management and health policy information, analysis, consultation, and technical assistance primarily for key stakeholders in the Commonwealth; and to provide leadership in educating health professionals, policymakers, students and the public in health services research, policy and management. F. Douglas Scutchfield, M.D., serves as Director of the Center.



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# Summary

The possibilities for medical science appear virtually unlimited, yet a growing number of Americans do not have access to necessary primary and preventive health care because they cannot afford it. Despite sustained job growth and record low unemployment, the nation's uninsured population increased by an average of 1 million people a year over the past decade, according to the U.S. Census Bureau. Without a structural remedy for this persistent flaw in our system, public and private responses to the rising cost of health care may further limit inclusion. Thus, the dilemma of access to health care in the United States may become more complicated and more difficult to resolve.

While trends in Kentucky differ somewhat, health care here suffers from many of the same maladies that affect other states and the nation as a whole. Annual estimates of the uninsured population over the past three years suggest a slight decline in the state's uninsured population, but economic and social trends threaten to push health insurance out of reach for more Kentuckians. Today, fewer workers are covered by employer-sponsored health insurance plans even though more employers are offering them. The rising out-of-pocket premium cost and increased copayments and coinsurance have made insurance less affordable for many. At the same time, some of the fastest growing sectors in our economy are those in which uninsured rates are highest. Conversely, employment is expected to decline in the manufacturing sector where insured rates are highest. The dominance of small firms in the Kentucky economy is also a strong predictor of high proportions of uninsured workers, as small employers are far less likely to offer coverage. About one fourth of Kentuckians work for employers who have fewer than 20 employees and are therefore far less likely to offer health insurance.

The historically lower family incomes and wage rates and high poverty rates found in Kentucky are consistently linked to high uninsured rates. Residents of rural areas like those where about half of all Kentuckians live are also more likely to be uninsured. Some studies suggest that the progress of welfare reform and the movement of former recipients into low-wage jobs that offer no benefits are directly linked to the rising population of uninsured. Though many remained eligible for coverage, these new labor force entrants may not have been adequately informed of their continued eligibility—and their children's.

As the problem of the uninsured grows, an increasing portion of the cost of patient care has gradually shifted from the private sector to the public sector. In 1998, government met nearly half of the nation's health care expenditures, an unusual circumstance in a country where the concept of government-run or "socialized" health care is not widely accepted. And the public's share is a particularly costly one. Publicly funded health insurance programs shoulder responsibility for those at highest risk of poor health, the old, the disabled, and the poor, whose health status is consistently poorer than younger persons and those in higher income categories. Thus, the challenge of expanding access is growing more complex and more difficult to solve.

## The Impact of Government Initiatives on Kentucky's Health Care System

Ambitious state and federal attempts to implement universal health care have given way to cautious incrementalism even as the private market has changed significantly. The State Children's Health Insurance Plan marks the first expansion of entitlement for health insurance since 1966, according to the Kaiser Commission on Medicaid. In the commercial health insurance market, managed care's market penetration is growing rapidly, and fee-for-service coverage is becoming increasingly scarce and expensive. Publicly funded health coverage has followed the commercial market trend to managed care products.

In Kentucky, the General Assembly has attempted to make private health insurance, rather than government programs, the vehicle for improved health care access. The 1994 Health Reform Act, which came in response to a series of town meetings and task force recommendations, centralized much of the control over Kentucky's health care system, establishing a Health Policy Board to regulate the health care industry and form a statewide purchasing cooperative to give Kentuckians access to lower-cost coverage. At the same time, the reform legislation greatly increased health data-sharing requirements, imposed a tax on providers, and placed new restrictions on the individual health insurance market.

The reforms mobilized powerful constituencies. A number of insurers left the state's individual market in protest over the reforms, and the tax on health care providers, which was designed to leverage federal Medicaid funds by increasing the pool available for the state's matching share, met with significant opposition. Although the provision was intended to improve provider reimbursement rates, several lawsuits and ultimately repeal of the tax followed.

A series of executive branch actions and a 1996 act that modified portions of the health reform legislation allowed insurers to extend policies with pre-reform benefits and premiums for about three years, by which time many of the original provisions had been repealed. The 1996 legislation abolished the Health Policy Board and reassigned its duties, but it also reflected the General Assembly's ongoing distrust of the health insurance industry. The 1996 Act imposed a series of unusually stringent provisions for rate reviews and hearings.

In its 1998 session, the General Assembly continued its rollback of reforms while retaining the core values of guaranteed issue and guaranteed renewability. Among other things, the Purchasing Alliance was abolished, limited experience rating was reintroduced, and a high-risk pool was created, requiring insurers to either participate in or contribute to a fund that would defray the costs of selected high-risk conditions. Consumer protections similar to those debated in the 1999 Congress were also adopted.

Kentucky's barrage of health reform initiatives is generally considered to have fallen short of its humanitarian goals. The primary beneficiaries of reform have been relatively affluent people whose health status led pre-reform insurers to reject their applications for coverage. Thus, attempts to increase the state's insured population without adding to the tax burden have fallen short in the absence of federal health reform. The only real shift has come in response to an irresistible federal funding opportunity that extends health insurance to more of Kentucky's poor children.

## Leadership Perspectives on the Future

To gain an informed perspective on the future of health care in the Commonwealth, we interviewed a sample of recognized leaders in the field, including: advocates on behalf of the public interest; payers or health insurance industry representatives; providers, including representatives of hospital, physician, and primary care organizations; and political leaders.

Many common themes emerged from these interviews, but concerns about the rising cost of health care dominated the discussions. While many of those interviewed expressed reservations about the state's ability to leverage constructive change, the more optimistic and more visionary among them perceived health care as an arena where the state of Kentucky can make a difference. They offered many policy options, as well as visions of the direction that health care here and around the nation should take. Some of the major conclusions these leaders offered were:

- Kentucky should establish a framework of values to inform health care decisionmaking.
- More information, expertise, and a coherent vision are needed.
- State government should exercise its considerable clout in purchasing health care.
- Consumer awareness of costs and options must be raised.
- Revenue must be identified and earmarked to finance health care needs.

- Community-level responses may offer workable solutions to problems with access, cost, and quality.
- Kentucky needs to place far greater emphasis on prevention and healthy lifestyle choices.

## What Works:

### Private and Public Initiatives to Improve Access to Health Services

In this chapter, we survey efforts to extend health insurance coverage that use both public and private sector programs, as well as community-based, voluntary initiatives. Insurance market reform alone has not succeeded in reaching a significant number of uninsured low-income Americans, but the ongoing need to contain public sector health care costs argues against over-reliance on tax-supported initiatives. The strategies described use Medicaid, state funding, combinations of Medicaid and state-only revenues, local tax initiatives, medical savings accounts, minimal benefit policies, high-risk pools, and several federal tax options, in addition to creative combinations of public and private support for comprehensive health programs.

Most states now use some form of Medicaid managed care, despite increasing evidence that while it helps contain cost increases, it does not generate net savings. Safety net providers still need subsidies to meet the needs of the uninsured. About half the states have local mandates that require communities to fund indigent care, but areas of highest need are likely to have the least resources, so exclusive reliance on this option often fails to meet local needs. Massachusetts, Minnesota, Oregon, Tennessee, and Wisconsin illustrate combinations of state-funded and Medicaid programs for specific categories of uninsured residents. States with a strong public health infrastructure and those with well-established managed care systems appear to have implemented the more stable and successful programs. Comprehensive health care needs are also met by diverse public-private initiatives across the country; several are profiled, with emphasis on the award-winning programs in Hillsborough County (Tampa), Florida, and Buncombe County (Asheville), North Carolina. In the Commonwealth, Health Kentucky and Kentucky Physicians Care exemplify the types of provider organizations that have made many programs across the country into sustainable vehicles for comprehensive service to low-income members of their communities.

Recent health care cost-containment proposals have focused almost exclusively on health insurance rather than the provider or consumer of health care, but the rise in health plan bankruptcies and receiverships across the country suggests that a sharper focus is in order. The aging Baby Boom generation will make even greater demands on health care providers and payers, new drugs and devices will offer genuine benefits at ever-increasing costs, and we are all likely to live longer with chronic (and costly) health conditions than our ancestors. A statewide—and national—dialogue is needed to address health care cost issues comprehensively, even if steps to improve access to care continue their current incremental path.

## Prescriptions for Change

Based upon the observations of the health care leaders interviewed for this report and on our research into state and community exemplars of expanded access, we offer policy recommendations that, we believe, will improve access to health care as well as health outcomes. We conclude that it is in the long-term interest of our state to begin meeting the needs of those who are not included in our system of health care, as we develop a new structure for decisionmaking and reform our system. Our recommendations are:

***Provide the tools and organizations for informed decisionmaking.*** The merits of establishing an impartial body or investing an existing group with the authority to act in an influential advisory capacity are considerable. In an arena full of vested interests, a reputable, objective body with access to reliable data *or* the resources and authority to collect and analyze data independently could make an enormous contribution to the future of health care in Kentucky.

***Recognize the limitations of insurance reform.*** We conclude that our efforts to enable access to health care through reform of the state’s individual and small group health insurance market have not significantly expanded access to health insurance for low-income Kentuckians. Comprehensive reform was not given sufficient time to prove its worth or its failure. While it is worthwhile to continue to learn more about the insurance market and to refine our regulatory framework after we have sufficient data in hand, the current state of the health insurance market in Kentucky suggests that the best legislative action in this area is no action.

***Identify and expand resources dedicated to health care.*** Whether we increase taxes, reallocate existing revenue, or earmark tobacco settlement dollars, additional funds will be needed to expand access to health care. Kentuckians have made health care a high priority in past and recent polls, but only a deliberate effort to assess public opinion will determine where they stand on expanding access to care and meeting its cost. An essential counterpart to expanding the resources we dedicate to health care is prudent purchasing. Finally, resources should be dedicated to the work of identifying existing sources of care and creating accessible networks for the uninsured.

***Enroll those who are currently Medicaid eligible and expand eligibility.*** The model state initiatives we profile in this report achieved lower uninsured rates principally by forthrightly addressing the need for revenue and expanding Medicaid eligibility. Particular attention should also be paid to enrolling Medicaid-eligible children whose parents lost coverage when they left welfare rolls, and to fashioning a more accessible, user friendly program that is relatively free of stigma.

***Focus on population health.*** The health care leaders interviewed for this report strongly advocated a focus on population-based health initiatives to improve the poor overall health status of Kentuckians. To do so, we must invest in the core public health roles that health departments have traditionally filled and marshal both public and private resources in a concerted effort to change health behaviors.



# Authors

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We are particularly grateful to the health care leaders from around the state who gave generously of their time to discuss the challenges health care faces in our state in in-depth interviews. Their sage observations and recommendations provide an important foundation for future efforts to make health care more accessible for citizens of the Commonwealth.

Specifically, we wish to thank the following individuals for their review of this report: Dr. Linda Blumberg, the Urban Institute in Washington, D.C.; Dr. Gilbert H. Friedell, Director Emeritus of the University of Kentucky Markey Cancer Center; Tony Goetz, Associate Dean, University of Kentucky College of Medicine; Bob Gray, the Kentucky Attorney General's Office; Jimmy D. Helton, Secretary of the Cabinet for Health Services; Peggy Hyland and Greg Freedman, the Kentucky Legislative Research Commission; Dr. Rice Leach, Commissioner of Public Health; and George Nichols III, Commissioner of the Department of Insurance.

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While many individuals contributed to this report, the Kentucky Long-Term Policy Research Center and the University of Kentucky Center for Health Services Management and Research assume full responsibility for its content. We welcome any and all comments.



## CHAPTER 1

# A Deepening Dilemma?

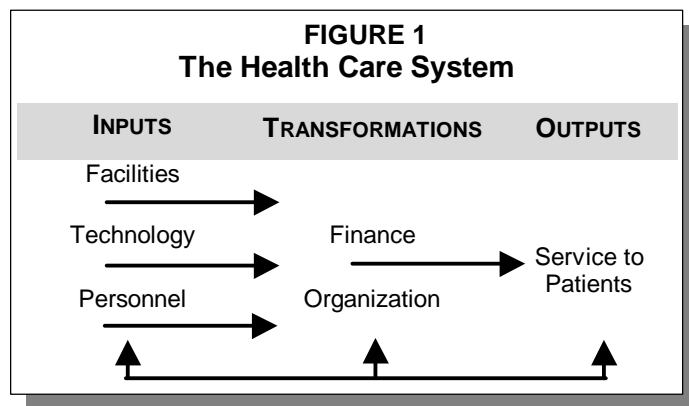
*The conflict between the potential of medical science and the reality of limited dollars is permanent*

Thomas Bodenheimer, 1999

Remarkable change and stubborn inertia coexist in U.S. health care. Medical science breakthroughs that are the envy of the world have made once-fatal illnesses and injuries manageable, even curable. While the possibilities for medical science appear virtually unlimited, our fundamental ability to provide health care to all who need it clearly is not. Access to the medical abundance of our entrepreneurial culture remains linked to economic status. Indeed, a growing number of Americans do not have access to primary and preventive health care because they cannot afford it. Without a structural remedy for this persistent flaw in our system, the rising cost of health care combined with public and private responses to the growing fiscal pressures these costs are producing may further limit inclusion. Thus, in the absence of effective action, the dilemma of access to health care in the United States may become more difficult to resolve.

As the interviews of Kentucky health care leaders conducted for this study clearly illustrate, containing the growth of health care costs—few have illusions about lowering them—is fast becoming a leading public policy priority. And for good reason. Demographic trends portend potentially unmanageable future public costs. The aging of Baby Boomers, who will form the largest generation of older citizens in the history of the nation, and the increased longevity of each successive generation are expected to present enormous fiscal challenges. By the late 2020s, the Urban Institute predicts that federal expenditures for just three mandatory spending categories—publicly financed health care, Social Security, and interest on the debt—will devour virtually all projected revenues based on current tax rates.<sup>1</sup> In short, no funds will be left to meet the myriad other challenges our nation faces.

With the steady increase of health care costs to individuals and institutions, many of the health care leaders interviewed for this report underscored the importance of increasing our understanding of the health care system. In spite of the notorious fragmentation of health services, a systems approach is essential to any coherent analysis. One reason why past legislative initiatives have had unintended consequences is the difficulty of analyzing U.S. health care as a system. However, as illustrated in Figure 1, health system inputs can generally be characterized as technology, facilities, and personnel. These inputs do not reach



<sup>1</sup> C. Eugene Steuerle, Edward M. Gramlich, Hugh Heclo and Demetra Smith Nightingale, *The Government We Deserve: Responsive Democracy and Changing Expectations* (Washington, DC: The Urban Institute Press, 1998).

consumers in the form of health services until they have been transformed by organization (i.e., health maintenance organizations) and finance (public and private insurance). As illustrated, the major components of the system are subject to external forces that, in turn, affect their relationships with the other components.

Like virtually all Americans, Kentuckians want access to high-quality health care at a reasonable cost. But each of the three items on this wish list—accessible, affordable, and excellent health care—is complex and difficult to define in operational terms. As we attempt to establish health care goals for our state and identify the incremental or structural changes that will move us towards their realization, we must anticipate the likely effects that a change in one angle of the access-cost-quality triangle is likely to have on the other two.

Traditionally, consumers have been spared exposure to the transforming functions in health care by a system in which no money appeared to change hands, no paperwork or oversight seemed to intrude, yet services almost magically appeared for middle-class Americans. Managed care has had the disconcerting effect of pulling back the curtain on health care organization and financing. Like Dorothy in *The Wizard of Oz*, we are now being forced to pay attention to the man behind the curtain—the manager in managed care systems, the policymaker behind publicly funded health plans. For the first time, many of us are becoming aware of the real cost of health care and the limitations those costs impose on the entire system, limitations that are likely to affect all of us.

Barometers of public opinion suggest that a significant portion of the public does not like what it sees behind the health care curtain. While rising costs and patient dissatisfaction with the quantity and quality of care in managed systems have garnered most of the headlines, public opinion polls show far higher levels of concern about the persistent problems with access to care. Americans register strong concern about a system that accommodates the needs of fewer and fewer people.

Whether we decide that the best interests of the nation or our state will be served by a system that breaks the current bond between access to care and economic or health status remains to be seen. Perhaps more so than ever before, however, the challenge of expanding access to health care is inextricably linked to that of containing and managing its cost. As the distinguished health economist Uwe Reinhardt puts it, the cost of “kind acts” that extend health services to low-income Americans may simply have exceeded our willingness to pay.<sup>2</sup> On the other hand, the long-range costs associated with a significant population of citizens who do not have access to health care may be just as great. And they are borne by all of us. Thus, confronting the difficult challenge of expanding access to health care is central to the long-term economic and social health of our state.

## Purpose of the Report

The genesis of this report can be traced to a 1997 survey of Kentucky health care leaders and a subsequent article in *Foresight*, a quarterly publication of the Kentucky Long-Term Policy Research Center, that analyzed findings from the survey. The survey, like this report, was the product of a joint effort of the Kentucky Long-Term Policy Research Center and the University of Kentucky Center for Health Services Management and Research. In this mail questionnaire, we asked key informants from around the state to identify the health care issues they believed would dominate the public policy agenda in the years ahead and pose the greatest challenge for the institutions they represented. Diminishing access to health care registered the highest level of concern among respondents. To learn more about limitations on access in the Commonwealth and, more importantly, about how access to health care can be expanded in our state, our centers embarked on a collaborative effort. This report and a 1999 conference dedicated to health care are the products of that joint effort.

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<sup>2</sup> Uwe E. Reinhardt, “Employer-Based Health Insurance: R.I.P.” in S.H. Altman, U.E. Reinhardt, editors, *The Future U.S. Health Care System: Who Will Care For the Poor and Uninsured?* (Ann Arbor, MI: Health Administration Press, 1997).

We hope to inform state policymakers and interested citizens about the scope of the problem of declining access to health care, state and federal responses to it, leadership perspectives on its causes and solutions, and proven strategies for expanding access. Importantly, we hope this report will serve as a catalyst for policies that will support the systematic collection and analysis of data on health care outcomes and permit more informed policymaking. This report should also begin to illuminate some of the areas where examination and data collection are most needed. Finally, we hope this report sparks renewed interest and commitment to a dialogue among citizens, policymakers, and health care leaders about how best to close gaps in access to health care in Kentucky and at the national level.

The willingness to explore, experiment, test strategies, and revise them as needed will be critically important to the process of finding workable solutions to the problem of declining access to health care. Kentucky policymakers have long demonstrated a willingness to experiment with policies designed to expand access to health care. The entrepreneurial impulse they brought to this issue in the past will be key to crafting future solutions, regardless of past outcomes.

## Organization of the Report

The following chapter addresses some of the important features of health care in Kentucky, showing the gradual erosion of health care coverage that is affecting many of the state's citizens and outlining the trends that are shaping the type and amount of health coverage employers are providing. It then turns to an issue that concerns us all, the burgeoning public cost of health care, and closes with an assessment of the current incremental legislative approach to health care.

Chapter 3 traces some of the landmarks in state and federal policy that have helped shape our modern health care system, with particular attention to the evolution of policy in Kentucky. We hope this discussion will increase public understanding of the complexity, interdependence, and weaknesses of our current health care system, which is profoundly influenced by national policy as well as by the quality and quantity of providers in our local communities.

In Chapter 4, we present the perspectives of health care opinion leaders in the Commonwealth, whom we returned to in 1998 and early 1999 for more in-depth interviews. To represent Kentuckians' diverse perspectives, we interviewed a sample of advocates, providers, payers, and some of the political leaders who must weigh the options. In free-flowing, open-ended interviews, these individuals were given the opportunity to discuss the health care issue or issues they believe will dominate the future agenda.

In Chapter 5 of this volume, we provide some emerging models from which we can learn new ways to advance our efforts to expand access, control costs, improve the quality of care, and achieve improved health outcomes in the Commonwealth. Additionally, these exemplars offer benchmarks by which we can measure our efforts. The final chapter of the report offers policy recommendations based upon our findings. <sup>a</sup>







## CHAPTER 2

# Trends Influencing Access to Health Care

While trends differ in depth and breadth in Kentucky, health care here suffers from many of the same maladies that afflict other states and the nation as a whole. Medical miracles—transplanted hands and hearts—coexist with persistently poor health outcomes. Research strongly suggests that poverty and the diminished access to health care and the behavioral tendencies associated with it lie at the root of Kentucky's disturbingly high rates of behavioral risk and chronic disease incidence and mortality. These health consequences have historically eroded both the state's productivity and its capacity to overcome a host of social and economic problems, not the least of which is poverty itself. Moreover, our population, which experienced a net loss of its youngest members in the 1980s and has become a magnet for retirees in the 1990s, is aging more rapidly than most. Like the general population, older Kentuckians are also poor by national standards.

The strong rural character of our state further complicates matters because poverty, poor health outcomes, and lack of health insurance are more extensive in rural areas, particularly in the Appalachian region of the state. The Center for Health Services Management and Research finds that, as with the U.S. population, nonelderly Kentuckians who live in rural areas are far more likely to be uninsured than those who reside in urban areas. While 10.2 percent of nonelderly urban respondents to the 1997 Kentucky Health Survey reported having no health insurance, 17.9 percent of rural residents reported having none. Rural, nonelderly residents of the state were also more likely than urban residents to depend on public insurance, 15.5 percent compared with 10.8 percent, respectively.<sup>3</sup> The rural communities where half of Kentucky's population lives are also more vulnerable to the job losses in health care that many predict will be the result of state and federal efforts to contain costs.

Kentucky is in the midst of the latest in a series of difficult and potentially disruptive health care upheavals, the product of federal changes aimed at containing rising health care costs. As in the past, they resemble a Darwinian test of survival rather than the product of intentional design. On the eve of the new millennium, fitness in the U.S. health care industry is measured almost exclusively in terms of efficiency, rather than by the capacity to improve the population's health. Ironically, the latest round of remedies, which reduce reimbursements to providers but do little to affect systemic costs, is widely predicted to exacerbate problems of access, effectively excluding more people from the health care system, even as public efforts are under way to expand coverage to more poor children. Thus, the question of how to expand access to health care continues to grow more complicated and more challenging.

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<sup>3</sup> F. Douglas Scutchfield, Joyce Beaulieu, and Kevin Lomax, "Who Are Kentucky's Adult Uninsured and What Impact Does Being Uninsured Have on Those Individuals?" *Policy Brief* University of Kentucky Center for Health Services Management and Research, Lexington, Kentucky, 1.1 (1998).

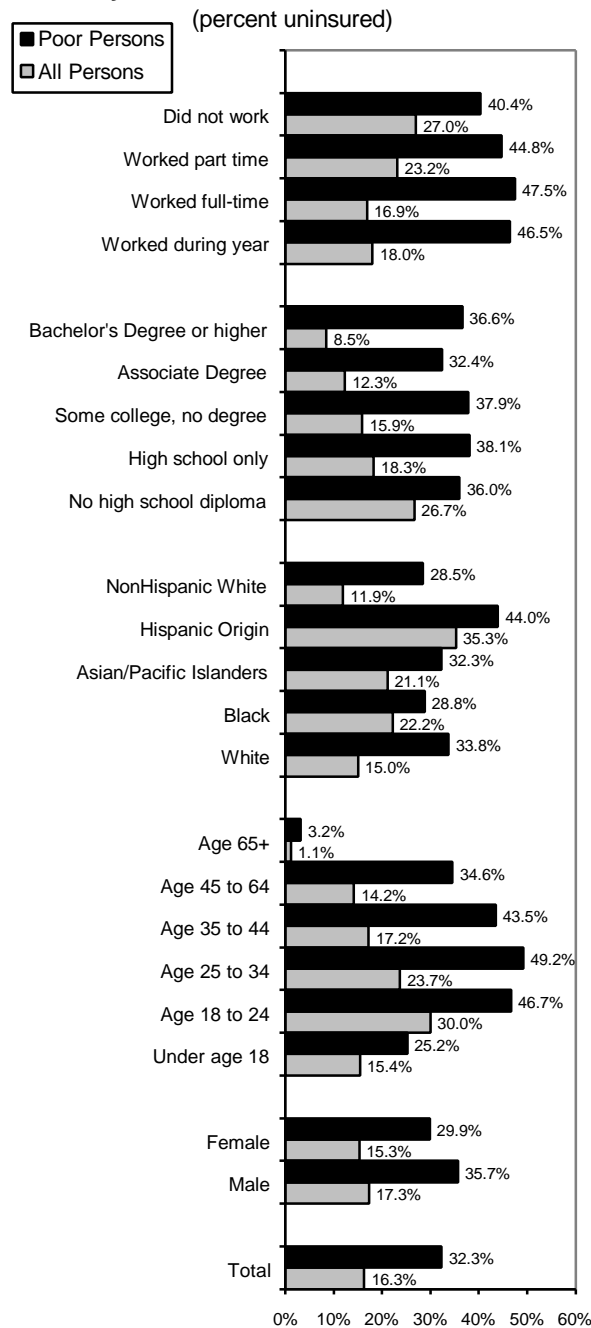
## Incremental Losses

With or without regulation, the health insurance marketplace has not yielded broadly affordable and accessible coverage or services. Insurers blame regulatory constraints and provider abuses for increased costs, while others point to a more fundamental issue, that is, the inappropriateness of ceding too much control of health care to an industry whose financial survival depends upon avoiding the costs associated with risk. Five years after the most recent proposal for national health care was abandoned, our chosen path of incremental reform has not improved access. Instead, rising costs and other social and economic forces are pushing more and more Americans into the ranks of the uninsured despite sustained job growth and record low unemployment, while cost-conscious public sector budgets threaten access to basic services for the uninsured.

Over the past decade, the ranks of the uninsured have increased by an average of 1 million people a year, reaching the highest level for the decade in 1998.<sup>4</sup> According to the U.S. Census Bureau, an estimated 16.3 percent of the total U.S. population, including the elderly who have universal access to Medicare, or 44.3 million people were without health insurance in 1998, up 800,000 from the previous year's estimate.<sup>5</sup> Even among households with incomes between \$50,000 and \$74,999 a year, 11.7 percent were uninsured in 1998 while 8.3 percent of those in households with incomes of \$75,000 or more were uninsured.<sup>6</sup>

In Kentucky, annual estimates over the past three years have suggested a steadily declining popula-

**FIGURE 2**  
**Poverty and Health Insurance Status, 1998**



<sup>4</sup> Robert Pear, "Ranks of Uninsured Continue to Swell," *Lexington Herald-Leader* 4 Oct. 1999: A-1.

<sup>5</sup> Pear, "Ranks ..."

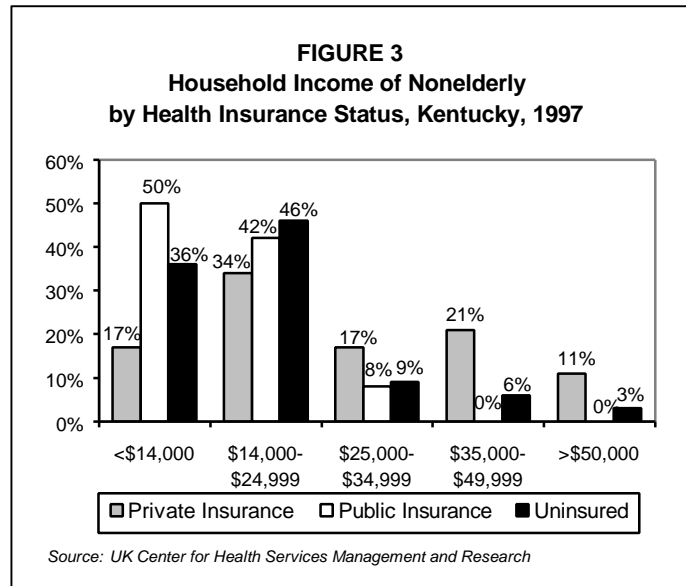
<sup>6</sup> Jennifer A. Campbell, "Health Insurance Coverage: 1998," *Current Population Reports*, U.S. Census Bureau, Washington, DC, Oct. 1999.

tion of uninsured, down from 15.4 percent in 1996 to 15.0 percent in 1997 to 14.1 percent in 1998. Given standard error rates, the three-year average (1996-1998) for the uninsured population in Kentucky could be virtually the same as the national rate. Moreover, the progress of welfare reform may have further increased the uninsured population in the ensuing months since these data were collected. On the other hand, these data may indicate a rising insured population in the Commonwealth, possibly as a consequence of increased employment, a tight labor market in some of the state's more populous areas, and the overall health of the economy.

While the numbers of uninsured are uncertain, the causes are not. Poverty is the common denominator among the uninsured. Regardless of sex, race, education, employment status, or citizenship, those with incomes below the federal poverty line are almost twice as likely to be without health insurance as the general population. As illustrated in Figure 2, the U.S. Census Bureau's March 1998 Current Population Survey found that 32.3 percent of poor persons did not have health insurance coverage throughout 1998, compared to 16.3 percent of all persons. Only 15.5 percent of the U.S. poor had employment-based health insurance coverage compared to 61.4 percent of all persons. As incomes rise, the chance that households will have health insurance coverage increases dramatically. In 1998, 25.2 percent of U.S. households with incomes below \$25,000 a year did not have health insurance compared to 11.7 percent of households with incomes ranging from \$50,000 to \$74,999.<sup>7</sup> As Figure 3 illustrates, an analysis of the 1997 Kentucky Health Survey by the University of Kentucky (UK) Center for Health Services Management and Research shows the same strong relationship between income and insured status in Kentucky.<sup>8</sup>

The United States remains the only advanced industrial nation that does not assure universal access to medical services. And the problem has continued to worsen. In 1997, 18.3 percent of the nonelderly population was uninsured, compared with 14.8 percent in 1987.<sup>9</sup> Most of the decline in rates of insurance coverage since 1993 is attributable to declining enrollments in publicly funded coverage such as Medicaid. According to the U.S. Census Bureau, the percentage of the population covered by Medicaid has declined steadily since 1995 when 12.1 percent were covered. Between

1996 and 1997, the portion of the population covered by Medicaid declined by a full percentage point from 11.8 percent to 10.8 percent, and by another half a percentage point between 1997 and 1998, from 10.8 percent to 10.3 percent.<sup>10</sup>



<sup>7</sup> Campbell.

<sup>8</sup> Scutchfield, Beaulieu and Lomax.

<sup>9</sup> P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey," *EBRI Issue Brief* 1998 Dec. (204): 1-27.

<sup>10</sup> Campbell, 1999; Robert L. Bennefield, "Health Insurance Coverage: 1995, 1996, 1997," *Current Population Reports* U.S. Department of Commerce, Economics and Statistics Administration, Washington, DC, Sept. 1996, Sept. 1997, and Sept. 1998.

The likelihood of an adult U.S. citizen having health insurance is directly related to:

- *employment status*: self-employed, unemployed, or part-time workers are much less likely to be insured;
- *employer size*: employers with fewer than 25 employees are less likely to sponsor group plans;
- *industry*: agriculture, food service, hospitality, and other service industries are less likely to offer insurance;
- *age and gender*: young males are more likely to be uninsured;
- *income*: even among wage earners, there is a direct relationship between hourly pay rate and the probability of having health insurance.

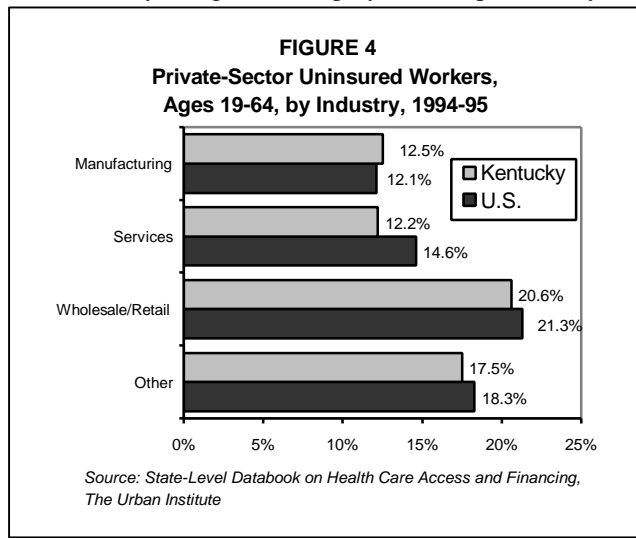
In spite of the link between employment and access to health insurance in the United States, Fraser notes a “strong, growing, paradoxical link between noncoverage and work.”<sup>11</sup> Among the general population, those who worked full- or part-time in 1998 were more likely to be insured than nonworkers were. Among the poor, however, those who worked were more likely to be uninsured than those who did not. Nearly half (47.5 percent) of poor, full-time workers did not have health insurance in 1998, compared with 16.9 percent of all full-time workers.<sup>12</sup> As Fraser observes, “The vast majority of the uninsured also are workers, or dependents of workers, for whom the current system somehow is not operating.”<sup>13</sup>

## Trends Influencing Employer Coverage

Employment remains the leading source of health insurance for Americans, providing coverage for 62 percent of all persons in the United States,<sup>14</sup> but a number of labor force and industry trends suggest that employer-provided health insurance is a declining source of coverage. Faced with steadily rising costs, employers have pared away costly benefit provisions. Employees are

increasingly likely to be required to contribute to their health insurance premiums, according to an Employee Benefits Research Institute (EBRI) study. While 44.2 percent of workers with employee-only coverage were in plans fully financed by their employers in 1987, only 32.5 percent were in 1996. Likewise, 36.7 percent of 1987 workers had family health care coverage paid for by their employers. By 1996, only 25.9 percent of workers had such coverage.<sup>15</sup>

The rising number of lower-wage jobs in wholesale and retail



<sup>11</sup> Irene Fraser, “Access to Health Care” in T.J. Litman and L.S. Robins, editors, *Health Politics and Policy*, 3rd edition (Albany, NY: Delmar Publishers, 1997): 13.

<sup>12</sup> Campbell.

<sup>13</sup> Fraser, 13.

<sup>14</sup> Campbell.

<sup>15</sup> Employee Benefits Research Institute (EBRI), “EBRI Health Care Research: 1998-99 Findings,” *EBRI Online* at: [www.ebri.org/health\\_findings.htm](http://www.ebri.org/health_findings.htm), 18 May 1999. EBRI, however, finds that required employee contributions as a percent of the total health insurance premium varied little over the same time period. Today’s tight labor market, which has intensified competition for workers, may be discouraging further erosion of benefits.

sales, where national uninsured rates averaged 21.3 percent over 1994-95, also suggests more rather than fewer workers are likely to be without employer-provided health insurance in the coming years. By comparison, 14.6 percent of U.S. workers in the services industry and 12.1 percent of workers in the manufacturing sector were without health insurance.<sup>16</sup> Employment in the manufacturing sector, where insured rates are highest, is widely predicted to decline. As shown in Figure 4, Kentucky's percentage of uninsured workers is somewhat higher than the national average in the manufacturing industry, but lower in other industrial categories.<sup>17</sup>

While job growth and low unemployment have reduced the ranks of contingent (such as temporary or contract) workers somewhat in recent years,<sup>18</sup> the young adults who hold a disproportionate share of these jobs are far less likely to have access to health insurance. More than half of "temps" (temporary workers), according to a study by the 2030 Center, an advocacy and research group that represents the economic interests of young adult Americans, are between the ages of 20 and 34,<sup>19</sup> and only 5.1 percent of them have health insurance compared to 50.5 percent of all workers.<sup>20</sup> EBRI finds that more than half of all uninsured contingent workers, of which temps are but one type, report not having health insurance because it is not offered by their employers.<sup>21</sup>

The small firms that are the backbone of Kentucky's and, increasingly, the nation's economy are significantly less likely than mature, large firms to provide workers access to health insurance. In 1998, firms with fewer than 25 employees were the least likely to offer employment-based health insurance; only 29.3 percent of employees of these firms had employment-based insurance compared to 53.3 percent of all workers and 66 percent of those employed by firms with 500 or more employees.<sup>22</sup> The Urban Institute analysis of 1994-95 Current Population Survey data, while not directly comparable, suggests the scope of the problem in Kentucky: 26.3 percent of workers in firms with fewer than 100 employees, where about 55 percent of Kentuckians worked in 1995,<sup>23</sup> did not have health insurance, compared to 25.2 percent nationally. By contrast, just 8.8 percent of workers in Kentucky firms with 100 or more workers were uninsured, compared with 10.8 percent at the national level.<sup>24</sup>

Importantly, the increased cost of insurance, rather than declining availability, may be at the root of rising uninsured rates among workers. Recent research from the federal Agency for Health Care Policy and Research finds that more people are being offered employment-related health insurance but fewer are taking it. Between 1987 and 1996, the number of workers age 21 through 64 who were offered insurance by their employers grew by 3 percentage points, from 62.9 million to 75.5 million workers. However, the "take-up" rate, the proportion of employees offered health insurance who are covered through their main source of employment, declined by 8.2 percentage points, from 88.3 percent of workers to 80.1 percent.<sup>25</sup> The percentage of workers with access to employment-related health insurance through a spouse or parents remained virtually unchanged over the study period. Paradoxically, "although more workers were offered insurance from their employers in 1996, the increase did not represent improved access to employment-related health insurance."<sup>26</sup>

<sup>16</sup> David W. Liska, Niall J. Brennan and Brian K. Bruen, *State-Level Databook on Health Care Access and Financing* (Washington, DC: The Urban Institute, 1998).

<sup>17</sup> Liska, Brennan and Bruen.

<sup>18</sup> Steven Hipple, "Contingent Work: Results from the Second Survey," *Monthly Labor Review* Nov. 1998: 22-35.

<sup>19</sup> Helene J. Jorgensen, *When Good Jobs Go Bad: Young Adults and Temporary Work in the New Economy* (Washington, DC: 2030 Center, 1999) online at: [www.2030.org](http://www.2030.org).

<sup>20</sup> Jorgensen.

<sup>21</sup> EBRI.

<sup>22</sup> Campbell.

<sup>23</sup> Bureau of the Census, *County Business Patterns 1995: Kentucky* (Washington, DC: Department of Commerce, 1997).

<sup>24</sup> Liska, Brennan, and Bruen.

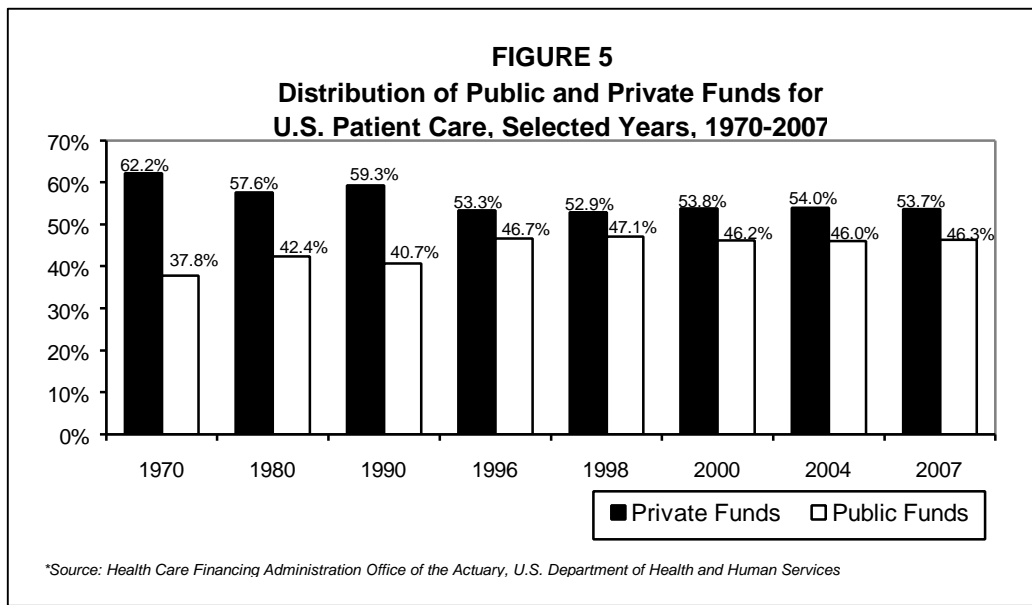
<sup>25</sup> Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs* 16 (1997): 142.

<sup>26</sup> Cooper and Schone: 144.

These researchers also found that the strong relationship between how much people earn and their access to employment-related health insurance intensified between 1987 and 1996. Even as the overall rate of employer offers of insurance increased, lower-wage earners became significantly less likely to be offered insurance by their employer, to take it if offered, or to have access to it from other sources. Employer offers of health insurance also declined among the youngest workers under age 25, who are the most likely age group to be uninsured. Although women made gains, they are far more concentrated than men in low-wage occupations, and thus remained significantly less likely to be offered health insurance by their employers.<sup>27</sup>

## The Growing Public Cost

Because the issues underlying access to health care in the United States have remained unresolved and unaddressed throughout much of this century, today's health care system is the product of conflicting perspectives. Its costs, if not its coverage, are nearly equally divided between the public and private sectors. The trend across recent decades has been towards greater public responsibility for health care, a shift one Kentucky health care leader refers to as "privatizing the profit while socializing the cost." As illustrated in Figure 5, an increasing portion of the cost of patient care has gradually shifted from the private sector to the public sector since 1970, with more rapid growth occurring in the early 1990s. As managed care penetrates further in the public sector and Medicaid rolls continue to decline, projections from HCFA's Office of the Actuary show a leveling of the public share of costs from 1999 through 2007 at around 46 percent.<sup>28</sup> In 1998, the public share of health expenditures, principally for Medicare and Medicaid, reached a high of 47.1 percent, an unusual circumstance in a country where the concept of government-run or "socialized" health care lacks wide acceptance.



But the public's share is a particularly costly one. Publicly funded health insurance programs such as Medicare and Medicaid shoulder responsibility for those citizens who are at highest risk of

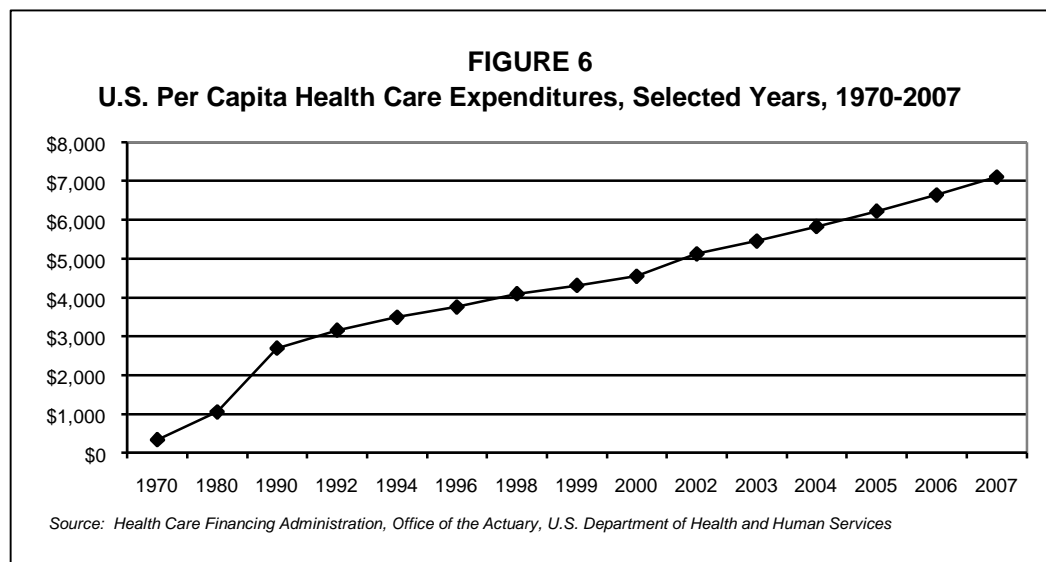
<sup>27</sup> Cooper and Schone.

<sup>28</sup> Health Care Financing Administration (HCFA) Office of the Actuary, Table 1, "National Health Care Expenditure Amounts, Percent Distribution, and Average Annual Percent Change, by Source of Funds: Selected Calendar Years, 1970-2007," online at: [www.hcfa.gov/stats/nhe%2Dproj/tables/t01](http://www.hcfa.gov/stats/nhe%2Dproj/tables/t01), 15 Oct. 1998.

poor health, including the old, the disabled, and the poor, whose health status is consistently below those in higher income categories. While government programs insured only about a quarter (24.3 percent) of the 1998 population through Medicaid, Medicare and the military,<sup>29</sup> the public sector's share of 1998 national health expenditures was nearly double that percentage (47.1 percent).<sup>30</sup> In an analysis of responses from Kentucky Health Surveys conducted by the UK Survey Research Center from 1993 through 1997, the UK Center for Health Services Management and Research found that Medicaid recipients, some of whom qualify for benefits because of health conditions, had the lowest health-related quality of life scores among the state's insured.<sup>31</sup>

While growth in the cost of health care moderated considerably in 1997 and 1998 after the double-digit rates of growth of the 1980s and early 1990s, the costs have begun to accelerate again. An unprecedented level of consumerism has affected health care in the waning years of the 20th century. The direct marketing of pharmaceuticals and other health services has driven up demand for costly and arguably unnecessary drugs and medical tests. Ironically, the rate of consumption of health care, which would ordinarily suggest considerable faith in conventional U.S. medicine, coexists with the rise of alternative medicine and health information as commodities and emerging industries in their own right.

Estimates indicate that this cost acceleration will continue. The Congressional Budget Office and HCFA's Office of the Actuary predict that during the first decade of the new millennium national health spending will more than double, rising from \$1.0 trillion in 1996 to about \$2.1 trillion in 2007, and spending for health care as a percent of the gross domestic product will rise from 13.6 percent to 16.6 percent.<sup>32</sup> While the average annual rate of growth is expected to be contained by managed care and, for a time, by provisions of the Balanced Budget Amendment of 1997, it will steadily tick upward for virtually every type of health care spending between 2001 and 2007. By 2007, per capita expenditures for health care will reach an estimated \$7,100, an 88 percent increase in spending over the 1996-2007 decade. As illustrated in Figure 6, per capita health care spending in constant dollars has risen dramatically over the course of recent decades, from just \$341 per person in 1970 to a projected \$7,100 in 2007.



<sup>29</sup> Campbell.

<sup>30</sup> HCFA, Table 1.

<sup>31</sup> Joyce Beaulieu, Mark Lancaster, F. Douglas Scutchfield, Carol Ireson, and Kjell Johnson, "Health-Related Quality of Life in the 1990s," *Policy Brief*, Center for Health Services Management and Research, University of Kentucky, Lexington, 2:1 (1999).

<sup>32</sup> HCFA, Table 1.

Rising health care costs will inevitably force those who have health insurance to become more responsible for, and thus more aware of, the real cost of their care, from which they have remained comfortably insulated for many years. Health insurers, for example, already have begun to drop or find less costly replacements for many popular, high-cost pharmaceuticals in their formularies in an effort to control skyrocketing drug costs. Express Scripts, the nation's largest independent pharmacy benefit manager, reported in June 1999 that pharmacy benefit costs rose 16.8 percent in 1998, as the prices of widely used medications rose between 10 percent to 20 percent. Drugs introduced since 1992 accounted for 35.6 percent of the cost increase,<sup>33</sup> attesting to the power of marketing, patent protection, and the increasing effectiveness of new medications.

In turn, out-of-pocket expenditures and insurance copayments are likely to continue rising as insurers—and employers—shift more of the cost of care to individuals. As in other spending areas, the Congressional Budget Office predicts that private, out-of-pocket payments in the United States will rise from \$191 billion in 1996 to a projected \$342 billion in 2007, an overall increase of 79 percent.<sup>34</sup> Out-of-pocket payments are predicted to rise from 4.4 percent of national health expenditures in 1996 to 5.9 percent in 2007,<sup>35</sup> an estimated annual increase of about \$444 per person in the United States over the course of a decade.<sup>36</sup>

## The Progress of Incrementalism

To date, the chosen path of incremental reform has not yielded effective responses to the expanding rolls of uninsured Americans or to the threat of unmanageable health care costs. Passage of the Health Insurance Portability and Accountability Act (HIPAA) by Congress in 1997 was intended to help preserve access to health insurance benefits across job changes. But state and federal officials report that the law has had minimal impact on the individual market as insurance companies continue to exclude the sick in states that have not prohibited the practice or charge exorbitant rates to customers with pre-existing conditions.<sup>37</sup> The law did not address insurance rates and thus left the fundamental issue of affordability unresolved. As a consequence, the HIPAA has provided no protection to those whose medical histories mean unaffordable premiums.

Important national investment, however, has been made in health insurance for children in low-income families. As part of the Balanced Budget Act of 1997, Congress appropriated \$20.3 billion over five years to help states extend coverage to a broader population of uninsured poor children under the State Children's Health Insurance Program (SCHIP). Kentucky was one of the last states to implement its SCHIP program, although a modest extension of Medicaid coverage to 14-18 year olds up to 100 percent of the federal poverty level was initiated on July 1, 1998. After rejecting responses to a request for proposals that would have established a non-Medicaid CHIP in Kentucky, the Cabinet for Health Services implemented a Medicaid expansion up to 150 percent of the federal poverty level on July 1, 1999; the income eligibility ceiling rose to 200 percent on November 1, 1999.

Because a significant number of Medicaid-eligible children historically have not been enrolled in the program, further expansion may not close these gaps in coverage. Overall, it is estimated that between 1.6 and 4.5 million children in the United States live in households that are eligible for Medicaid but do not receive it.<sup>38</sup> While some evidence suggests that data from the Census Bu-

<sup>33</sup> Express Scripts Inc., "Depression-Treating Drugs Lead Record-Setting Pharmacy Benefit Cost Rise," (news release) 29 June 1999, online at: [www.express-scripts.com](http://www.express-scripts.com), 23 August 1999.

<sup>34</sup> Congressional Budget Office (CBO), "Trends in Health Care Spending by the Private Sector," Washington, DC, Apr. 1997.

<sup>35</sup> CBO.

<sup>36</sup> Kentucky Long-Term Policy Research Center estimates based on July 1, 1998, Social Security area population estimates as cited by HCFA and projected out-of-pocket expenses from the Congressional Budget Office.

<sup>37</sup> Robert Pear, "Government Lags in Steps to Widen Health Coverage," *New York Times* 9 Aug. 1998: 1.

<sup>38</sup> Cindy Mann and Jocelyn Guyer, "The President's Budget Includes New State Options for Reducing the Number of Uninsured Children" (news release), Center on Budget and Policy Priorities, Washington, DC, 10 Apr. 1998.



reau's annual Current Population Survey underreport Medicaid coverage, averages for 1994-1995 show that 94,500 or 18 percent of Kentucky children living in households with incomes below 200 percent of the poverty level were uninsured, compared with 14.3 percent at the national level.<sup>39</sup> A 1998 Legislative Research Commission memorandum estimated that 123,000 uninsured children would qualify for benefits under Medicaid or KCHIP.<sup>40</sup> By September 1999, KCHIP had enrolled 20,594 Kentucky children in the new program, according to the Cabinet for Health Services. When Phase III of the program goes into effect in November 1999 and extends coverage to children in households with incomes up to 200 percent of the federal poverty level, the number of children who are covered is expected to grow substantially.

Here as well as nationally the progress of welfare reform has proven a countervailing force to the expansion of children's health insurance. According to the HCFA, Medicaid covered 4.1 percent fewer adults and 1.4 percent fewer children in 1996 than in 1995, and most of this decline relates to the lower numbers of children and adults enrolled in Medicaid through state welfare programs. Additionally, many former welfare mothers—and their children—lost health insurance through Medicaid when mothers left welfare rolls to take jobs that offered no health care benefits. A significant portion of these women and their children may still be eligible for Medicaid but were not re-enrolled. Families USA, a Washington, D.C., consumer advocacy group, concludes that one in five women who left welfare became uninsured.<sup>41</sup> Other studies have reached similar conclusions.<sup>42</sup>

Myriad bills that offer diverse strategies for expanding access to health care have languished in Congress. Early retirees were identified in 1998 as a growing population of the uninsured who were being left without coverage when their former employers abandoned their costly pension commitments, so the president proposed extending Medicare coverage at cost to the 55-64 age group. Congress demurred. While polls suggest that the growing inaccessibility of health care has again assumed a high priority in voters' minds, congressional attention has been largely focused on consumer protection bills for the insured.

In the meantime, at the state and national level, the public sector is deliberately moving away from a system in which it paid an inflated price for health care, a portion of which was then shifted to meet the cost of uncompensated health care and other health care needs. But, as with any system, however flawed, no one element can be altered or removed without causing disruption or even collapse in other areas. The excessive costs of the past that have become the target of so-called "market reforms" helped finance services like indigent care and teaching hospitals. Some of the outcomes of our zealous efforts to reduce costs have already given rise to legislative proposals designed to address unintended consequences.

Efforts to move more public sector health care recipients into managed care plans have also met with myriad problems. Physicians in some regions, such as western Kentucky, have resisted managed care, public or private. Some private health maintenance organizations (HMOs) in other states have abandoned these public sector partnerships in the face of declining reimbursements and unmanageable costs, preferring instead to healthier and more affluent populations.

Several health care leaders we interviewed fear that Medicare reimbursement schedules set forth in the federal Balanced Budget Act of 1997 combined with the state's movement into Medicaid managed care will ultimately leave significant gaps in an already inadequate safety net and deplete services in rural areas. Some rural hospitals and other medical providers that are essential to the social and economic health of communities across Kentucky could be lost as reduced reimbursements cut into revenues. Some of these providers are part of the state's fragile, piecemeal

<sup>39</sup> Liska, Brennan and Bruen.

<sup>40</sup> Legislative Research Commission (LRC), Research Memorandum No. 480, Jan. 1998, Frankfort, Kentucky.

<sup>41</sup> Families USA, *Losing Health Insurance: The Unintended Consequences of Welfare Reform* (Washington, DC: Author, 1999).

<sup>42</sup> Vernon K. Smith, R.G. Lovell, K.A. Peterson, M.J. O'Brien, *The Dynamics of Current Medicaid Enrollment Changes: Insights from Focus Groups of State Human Service Administrators, Medicaid Eligibility Specialists and Welfare Agency Analysts* (Washington, DC: Henry J. Kaiser Family Foundation, 1998).

system of health care for the indigent. Over the long term, some Kentucky health care leaders believe that many providers could be propelled out of rural communities and into more densely populated areas, as the support networks of specialists, clinics, and hospitals on which they once relied are weakened. Thus, the safety net in Kentucky, which has survived partly on charity but largely on the cost-shifting practices of the past, is fraying. Without replacement revenues, many providers of indigent care, from primary care clinics in health departments to community hospitals, could be lost. ☒



## CHAPTER 3

# The Impact of Government Initiatives on Kentucky's Health Care System

Ambitious state and federal attempts to implement global health care change have given way to more modest programs. Neither state nor national constituencies have been willing to tolerate short-term cost, inconvenience, or access limitation in the name of long-term goals. The consequences of targeted initiatives are almost as complex as those of broader programs, but some health care policy options are proposed repeatedly over time, and recent history can provide clues to their likely effects on health care cost, quality and access. In the following pages, we describe federal initiatives as they have affected Kentucky, and place Kentucky's health reform work in the context of national trends.

## Federal Health Care Initiatives

Plans to create a national health insurance system have appeared sporadically throughout the century.<sup>43</sup> Roosevelt's 1936 Social Security Act could easily have included national health insurance if his advisors had not feared that its inclusion would jeopardize the success of the entire initiative. In 1942, 1946, 1948, and 1950, Senators Wagner and Murray and Representative Dingell introduced a bill to provide a national health insurance plan. In spite of support by President Truman, the bill was never enacted, largely as the result of the American Medical Association's violent opposition. In contrast, the successful initiatives of Senator Kerr and Representative Mills in the early 1960s led to the enactment of a predecessor to Medicaid, providing matching funds to states that wished to participate in meeting the costs of medical care for the elderly poor.

The most successful national health insurance initiative of the century was the 1966 legislation (after a remarkable political battle) authorizing Medicaid and Medicare, which expanded financial access to health care for the nation's poor and elderly.<sup>44</sup> Although intended by their chief architects as bridges to universal coverage, Medicare and Medicaid were not succeeded by broader initiatives and thus became the only available vehicles for congressional attempts to address health care access, cost, and quality. In the name of cost containment, Medicare became the laboratory for new ways of reimbursing providers, such as Diagnostic Related Groups and the Resource-Based Relative Value Scale. On behalf of quality improvement as well as cost containment, Profession Standards Review Organizations (now Professional Review Organizations) were grafted onto Medicare.

Medicare may again be called into service on behalf of early retirees if current proposals to allow them to buy Medicare coverage are enacted. Likewise, to improve access for targeted groups of low-income and vulnerable Americans, Congress has allowed states to expand Medicaid eligibility. It should come as no surprise that many states have used Medicaid as the administrative

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<sup>43</sup> Richard Harris, *A Sacred Trust* (Baltimore, MD: Pelican Books, 1969).

<sup>44</sup> Emily Friedman, "The Compromise and the Afterthought," *JAMA* 274.3 (1995): 278-82.

vehicle for the State Children's Health Insurance Program, which expands income-based eligibility criteria for children.<sup>45</sup>

Medicare and Medicaid have long enough track records that changing them has reasonably predictable fiscal and organizational consequences. In contrast, other health-related initiatives have tended to overcorrect. When federal policymakers decided to stimulate hospital construction at the end of the Second World War, they failed to foresee just how enthusiastically hospitals would embrace the prospect of federal funding for their capital projects.<sup>46</sup> Similarly, the Health Professions Education Assistance Act was intended to augment the inadequate supply of physicians by giving preferential visa treatment to international medical graduates, but policy analysts generally find that we now have too many physicians, at least in part as the result of those policy decisions.<sup>47</sup> During the 1960s, access-oriented legislation created community health centers, increased the number of physicians, and financed care for the poor and the elderly through Medicare and Medicaid. When more health services were available to more Americans, the nation spent more on health care.<sup>48</sup> In reaction, health policy initiatives during the 1980s and 1990s have focused primarily on cost control. As with the access initiatives, focus on cost control has achieved some success, but at the expense of adding a million Americans to the ranks of the uninsured every year and squeezing out the surpluses that once funded indigent care. Access, once the primary focus, has been circumscribed to contain costs.

Despite the failure of the Clinton health reform package, the 1990s have seen dramatic changes in the health insurance market, and these changes have been reflected in Kentucky. Managed care now accounts for 41.7 percent of Kentuckians with commercial health insurance coverage, up from 31.4 percent in January 1996. Indemnity or fee-for-service coverage is increasingly scarce and expensive, as exemplified by the insolvency of Kentucky's state-financed indemnity plan in 1998.

In contrast with the scale of market-driven changes, recent legislative initiatives have been relatively modest, reflecting the cautious reliance on incrementalism that has prevailed in the wake of the Clinton health plan debacle. In 1996, the Health Insurance Portability and Accountability Act (HIPAA)<sup>49</sup> was enacted as a modest attempt to make coverage more portable for persons changing jobs, and to mitigate discrimination against group health plan members with medical problems. Recent analyses suggest that the HIPAA will have a very limited effect because it does not address premium rates.<sup>50</sup>

Publicly funded health coverage has followed the commercial market trend to managed care products. The Balanced Budget Act of 1997 included provisions that could expand the variety of Medicare choices, again with very mixed results thus far.<sup>51</sup> Early results suggest a higher level of success for the new State Children's Health Insurance Plan, the first new expansion of entitlement for health insurance since 1966.<sup>52</sup> Current efforts to pass patient protection legislation further illustrate the prevailing strategy of incremental attempts to achieve health insurance reform on the federal level.

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<sup>45</sup> V.K. Smith, "Preliminary Estimates: Enrollment Increases in State CHIP Programs: December 1998 to June 1999" (Report prepared for the Kaiser Commission on Medicaid and the Uninsured), (Lansing, MI: Health Management Associates, July 1999).

<sup>46</sup> Stephen Williams and Paul Torrens, *Introduction to Health Services*, 5th ed. (Albany, NY: Delmar Press, 1999).

<sup>47</sup> Council on Graduate Medical Education, *Report to Congress and the Secretary, Department of Health and Human Services: Recommendations to Improve Access to Health Care Through Physician Workforce Reform* (Washington, DC: USGPO, 1994).

<sup>48</sup> See Williams, see note 4, at 114-115.

<sup>49</sup> Pub.L. 104-191, Aug. 21, 1996, 110 Stat. 1936; Pub.L. 105-33, title IV, Sec. 4311(b)(2), Aug. 5, 1997, 111 Stat. 386; Pub. L. 105-34, title XVI, Sec. 1602(f)(4), (5), Aug. 5, 1997, 111 Stat. 1095.

<sup>50</sup> Esther Hing and Gail A. Jensen, "Health Insurance Portability and Accountability Act of 1996: Lessons From the States," *Medical Care* 37:3 (1999): 692-705; Robert Kuttner, "The American Health Care System: Health Insurance Coverage," *New England Journal of Medicine* 340 (1999): 163-8.

<sup>51</sup> See, e.g., "Medicare HMOs: At Latest Count, 99 Plans Dropping Out," American Health Line, 16 July 1999.

<sup>52</sup> Smith, see note 3.

## Kentucky Health Reform

The past decade has seen a series of attempts on the part of the Kentucky General Assembly to make private health insurance, rather than government programs, the vehicle for improved health care access. The 1987 Report of the Commission on Financing Health Care for the Medically Indigent concluded:

*Despite the lack of data on the number of persons who would take advantage of expanded health insurance options, it can be reasonably assumed that making health insurance available to as many employed and formerly employed persons, dependents and former spouses as possible would be a useful tool in reducing medical indigence in the population.*<sup>53</sup>

The Commission recommended several measures that have become fixtures in more recent years: continuation extensions and special enrollment periods for those who lose access to employer-sponsored group plans, waivers of some pre-existing condition exclusions, student dependent coverage eligibility to age 24, and required notice of continuation rights. The Commission's list of potential disadvantages of health insurance reform could have been written 10 years later:

- employers burdened with these requirements would drop insurance altogether;
- broader access would lead to adverse selection; and
- incremental enhancements would fail to attract increased enrollment.

In March 1992, Governor Brereton Jones created a Task Force on Health Care Access and Affordability. After holding 15 regional meetings during the spring of 1992, the group issued a report that was incorporated into the Governor's Health Reform Plan in February of 1993. The Governor's Commission on Health Care Reform adopted 14 goals that were reflected in a 1993 Special Session bill sponsored by Representatives Burch, Long, and Scorsone. The May 1993 Special Session was called to address health reform, but only succeeded in creating yet another task force. Subcommittees on access, cost containment, and finance and Medicaid met from June until September 1993, when they presented a report to the full task force.

The report of the Subcommittee on Access of the Kentucky Task Force on Health Care Reform stated that "lack of health insurance is clearly the biggest barrier to adequate access."<sup>54</sup> While ultimately acknowledging that "obtaining universal coverage will require the use of substantial subsidies and incentives to purchase coverage,"<sup>55</sup> the Subcommittee clearly felt that the time was not ripe for such dramatic changes in health care funding. The Subcommittee also acknowledged other dimensions to access, including lack of providers and public transportation. Nevertheless, the dominance of the commercial insurance strategy (rather than direct-service funding or government-sponsored third party coverage) is reflected in the statement that insurance reform "is a necessary precondition for extending access and pursuing systemic change."<sup>56</sup> The Subcommittee recommended making insurance available through a statewide purchasing cooperative that would include all public sector employees on a mandatory basis with small group and individual purchasers eligible for voluntary membership.

## The 1994 Health Reform Act

The Health Reform Act enacted by the 1994 General Assembly included many provisions that centralized control over Kentucky's health care system. The Kentucky Health Policy Board established by the Act was responsible for health care workforce regulation, certificate of need, fee structure, and benefit design, as well as establishing and overseeing the statewide purchase-

<sup>53</sup> Legislative Research Commission, Report No. 223: 69.

<sup>54</sup> Legislative Research Commission (LRC), Subcommittee on Access, *Task Force on Health Care Reform, Final Report* (Frankfort: LRC, 1993).

<sup>55</sup> LRC 32.

<sup>56</sup> LRC 12.

ing cooperative. The 1994 Act greatly increased data-sharing requirements for health care providers and mandated posting of maximum fees. The high profile of the Board made it an easy target for legislative demolition of Kentucky's health reform initiative. Members of the Health Policy Board and the Kentucky Health Purchasing Alliance's board were not allowed to have been employed in health insurance, a restriction that avoided conflicts of interest, but deprived the boards of insurance expertise.

Controversial provisions in the 1994 Act imposed taxes on health care providers to increase the pool of funds available for the state matching share of Medicaid and qualify the state for increases in federal payments. Although this scheme was intended to improve provider reimbursement rates, opposition to the provider taxes led to several lawsuits and ultimately to their repeal. "Health reform" and "provider tax" were synonymous in the minds of many physicians, pharmacists, and hospital administrators, a circumstance that did not improve the atmosphere for implementation of system-wide change.

The 1994 Act delayed the effective date of the insurance reform provisions until July 15, 1995, to allow the health insurance industry to adapt its systems and processes. The new requirements included

- mandatory use of standard benefit plans for all state-regulated products;
- guaranteed issue and renewability of all products;
- a six-month limit on pre-existing condition exclusions;
- complete waiver of the exclusion period if the covered person had a hiatus in coverage of no more than 60 days; and
- modified community rating for plans issued to individuals, groups with up to 100 members, and statutory members of the Kentucky Health Purchasing Alliance.

The Alliance in its original form would have included virtually all-nonfederal public sector employees as mandatory members, and groups of up to 100 individuals as voluntary members. The 1994 legislation also contemplated the eventual merger of the Alliance with Medicaid.

One of the few 1994 mandates that has persisted through subsequent legislative revisions is the requirement that network-based health plans allow "any willing provider" to participate in their panels. While other states have "any willing provider" laws, Kentucky's is among the broadest because it applies to a wide range of health care providers; most such laws apply only to pharmacies. Because the "willingness" of the provider is gauged by the provider's agreement to abide by the terms and conditions set by the plan for participation, some restrictive contracting terms based on criteria of volume, quality of outcome, or reimbursement rates have been found by the Commissioner of Insurance to be consistent with the statute.<sup>57</sup>

Finally, the 1994 Act addressed Medicaid managed care initiatives by authorizing the state to apply for a federal waiver<sup>58</sup> that would permit managed care implementation. As of mid-1999, the Kentucky system of regional partnerships has been implemented only in the greater Lexington and greater Louisville areas.

<sup>57</sup> Letter from Commissioner of Insurance George Nichols III to James G. LeMaster of Anthem Blue Cross & Blue Shield Re: Coronary Services Network, 16 July 1999.

<sup>58</sup> See 907 Ky. Admin. Regs. 1:705; Ky. Rev. Stat. 205.6334; 42 U.S.C. 1315.

## The General Assembly's 1996 Modifications

The insurance reforms in the 1994 Act applied to state-regulated (i.e., not self-insured or government-sponsored) coverage as existing policies came up for renewal. However, a series of executive branch actions and the 1996 modification of health reform legislation allowed insurers to extend policies with pre-reform benefits and premiums for about three years, until the repeal of many of the provisions that would have modified these policies. Persons covered under these policies enjoyed a prolonged vacation from rate increases and suffered a rude return to reality when their premiums were adjusted to account for the three-year moratorium. Larger employers' coverage is generally exempt from state regulation because of a federal law, the Employee Retirement Income Security Act of 1974 (ERISA), which preempts state laws that would otherwise apply to self-funded, employer-sponsored health plans.

The combination of ERISA, the policy extensions, and the 1996 legislative exemption of association plans from insurance reform requirements seriously impaired the ability of the health reform legislation to have any measurable effect on Kentucky's health insurance market. People who were well-insured, healthy, and employed had the option of evading reform requirements, leaving an increasingly unattractive group to bear the brunt of regulation.

The 1996 General Assembly abolished the Health Policy Board and reassigned its duties to the Cabinet for Health Services and the Department of Insurance (DOI).<sup>59</sup> The Act lifted the mandate for Alliance enrollment by employees of state higher education institutions and city or county employees, but Alliance membership remained mandatory for state, school system, and judicial employees. The 1996 Act relaxed insurance reform provisions:

- guaranteed issue was available only after a 12-month Kentucky residency;
- the pre-existing condition exclusion was extended from six to twelve months;
- premium rating was loosened to allow for the use of gender and occupation as rating factors up to a 5:1 possible premium variation for all case characteristics; and
- insurers were allowed to submit nonstandard plans to DOI for approval.

These provisions took effect when the majority of post-reform policies had only been in place for a few months, greatly compounding the difficulty of any coherent analysis of the 1994 Act's effects.

The 1996 Act reflected the General Assembly's ongoing concern with rate increases and distrust of the health insurance industry in a series of unusually stringent provisions:

- the Insurance Commissioner was required to review rates and order refunds if they exceeded statutory parameters;
- a minimum 30-day waiting period was instituted between rate approval and effective dates, although rates would be deemed approved unless the Commissioner rejected them or called for a rate hearing;
- hearings were mandated for rate proposals that would raise premiums more than the sum of the medical care consumer price index plus 3 percent; and
- the Attorney General was designated as a consumer intervenor in all rate hearings, with access to DOI files on the rates at issue.

## 1998 General Assembly Actions

The General Assembly declined to enact any changes to the 1996 health reform statute in a 1997 Special Session, but the 1998 regular session hammered out a compromise that rolled back some of the more restrictive aspects of prior health reform initiatives while retaining the core values of guaranteed issue (although in a high-risk pool in some cases) and guaranteed re-

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<sup>59</sup> 1996 Acts Ch. 371.

newability.<sup>60</sup> Negotiations among provider, consumer, and insurer representatives took place under the auspices of a group that called itself the Kentucky Home Team to distinguish itself from out-of-state insurers who had left the Kentucky market. Legislative leadership was provided by Representatives Robert DeWeese (himself a physician) and Robert Damron.

The Health Insurance Portability and Accountability Act applied federal standards to health plans issued or renewed after June 30, 1997, but Kentucky was given an extension of time until the 1998 regular legislative session to develop conforming legislation. Most HIPAA requirements were already in place in Kentucky, and minor statutory modifications were enacted in the regular session to bring the balance of Kentucky insurance law into conformity.

Other aspects of the 1994 and 1996 Acts that were repealed or amended by the 1998 Act included

- the standard benefit plans (only one offering required);
- the Health Purchasing Alliance (abolished by July 1, 1999);
- reintroduction of a limited degree of experience rating;
- the establishment of a high-risk pool called the Guaranteed Acceptance Program (GAP) to which insurers could gradually move nongroup insured persons with specified diagnoses; and
- individual market guaranteed issue limited to federally eligible persons, although others could be guaranteed issue within the high-risk pool.

All insurers doing business in the state were required to either participate in or financially support the GAP. Anthem and Humana elected to participate, although Humana's enrollment has been negligible. The collapse of Kentucky Kare, the state's self-funded indemnity plan, has accelerated the movement of both state employees and individual insureds into managed care plans.

The 1998 Act also imposed a number of conditions on managed care plans that are similar to those subsequently debated in Congress on the subjects of network adequacy, denial and appeals procedures, emergency coverage, continuity of care, access to specialists, women's health, and genetic testing. The Act created a Division of Consumer Protection and Education in the Department of Insurance. Revenue-related provisions allowed individuals and small businesses to deduct the cost of health insurance from their state individual income tax beginning with the 1999 tax year, and repealed the provider tax on prescription drugs effective June 30, 1999.

## Aftermath

Kentucky's barrage of health reform initiatives is generally considered to have fallen short of the humanitarian goals of Governor Jones and his legislative supporters.<sup>61</sup> Major motivation for the initial health reform movement (in Kentucky as elsewhere) came from the need to restrain growth in state Medicaid expenditures by making commercial insurance more accessible and affordable. New legal requirements have mitigated insurers' traditional exclusionary practices, but the primary beneficiaries have been relatively affluent people whose health status led pre-reform insurers to decline their applications for coverage. Kentuckians prosperous enough and ill enough to fall into this category are only one small segment of the total number of uninsured. Current Population Survey statistics show no significant change in the number of uninsured Kentuckians.<sup>62</sup>

Insurers actively lobbied for repeal of the 1994 reforms, arguing that it was imperative to restore competition to the state's individual market. To date, however, none of the departed insurers, six of whom are subject to a five-year ban under HIPAA and some of whom are no longer in the health care business, has returned to Kentucky's individual health insurance market, in spite of

<sup>60</sup> 1998 Ky. Acts Ch 496.

<sup>61</sup> Len M. Nichols, Mark A. Hall, Katherine Swartz, and Adele M. Kirk, "Beyond HIPAA: Lessons from Reforms of the Individual Insurance Market," *Journal of Health Politics, Policy & Law* 25:1 (forthcoming February 2000).

<sup>62</sup> Figures compiled by Kentucky Legislative Research Commission, cited in Ky. Dept. of Insurance, "Kentucky's Health Insurance Reforms." Presentation to Annual Meeting, National Academy for State Health Policy, Cincinnati, OH, 2 Aug. 1999.



legislative efforts to create a more hospitable business environment. Three health insurance carriers have returned to the state but not the individual market. And, according to the Department of Insurance, Prudential Insurance Company of America, which has offered traditional, indemnity insurance, has notified DOI of its intent to withdraw from the small and large group market, affecting about 4,800 Kentucky policyholders, who will be given the choice of purchasing coverage through PruCare, which offers only managed care policies.<sup>63</sup>

When the 1994 Act was crafted and enacted, national health reform seemed likely, and Governor Jones' enthusiasm for the state's initiatives reflected his identification with President Clinton's policies as well as his personal moral principles. In retrospect, it was clearly unrealistic to make Kentucky's small, fragile state-regulated insurance market the engine of health reform in the absence of a national context of similar reforms. As in other states such as New York and Washington, market-based reform has been particularly hard on the nongroup market, traditionally the area where insurers "cherry-picked" healthy enrollees and rejected others. Although Kentuckians without access to group coverage have nominal guaranteed issue rights, their choices are limited and rates are high.

The very limited expansion in access engineered by Kentucky's health reform initiatives has probably cost more than was absolutely necessary because the frequent legislative changes created a state of perpetual disruption in the market.<sup>64</sup> As with recent federal initiatives, attempts to expand access by altering state-regulated health insurance market conditions have had very limited success. To the extent that reforms have allowed less healthy persons into the insured market, they may have increased costs for all insured persons, leading healthy Kentuckians to drop their coverage or seek less regulated options. Regardless of whether the premium rate increases in Kentucky accurately reflect the costs that carriers incur, it is clear that curbs on a carriers' ability to adjust rates to reflect increased costs are a major factor in their decision to leave specific markets.<sup>65</sup> Although the architects of Kentucky's 1994 health reform initiative would acknowledge that expanding access imposed some cost on premium payers, they appear to have underestimated the effect—both personal and political—of these increases. The interdependence of cost, quality, and access has thus persisted in Kentucky's health care market as well as nationally.

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## Kentucky's Insurance Reforms in a National Context

Recent exhaustive studies of health insurance market reforms issued by the Urban Institute,<sup>66</sup> the Department for Health & Human Services,<sup>67</sup> and other researchers,<sup>68</sup> conclude that all the reforms thus far attempted in the small-group market, whether relatively loose or stringent, have enjoyed little if any success. While some states report significant increases in the number of small employers offering insurance, these positive results are likely attributable in large part to overall increases in employment, the number of small businesses, and economic growth in general. Individual market reforms are strikingly less successful, and serious restrictions on insurance

<sup>63</sup> Kentucky Department of Insurance, "Report on the Implementation of House Bill 315 to the Interim Joint Committee on Banking & Insurance," 27 July 1998. Prudential has now merged with Aetna U.S. Healthcare.

<sup>64</sup> A recent study of the effect of health reform initiatives across the country suggests that it takes at least three years for positive market effects to appear. See Hing, note 51.

<sup>65</sup> Linda J. Blumberg and Len M. Nichols, *Health Insurance Market Reforms: What They Can and Cannot Do* (Washington: Urban Institute, 1998), online at: [www.urban.org/pubs/hinsure/insure.htm](http://www.urban.org/pubs/hinsure/insure.htm); Mark Hall, *Health Insurance Market Reform Study*, Winston Salem, NC, November 1998, online at: [www.phs.wfubmc.edu/insure/](http://www.phs.wfubmc.edu/insure/).

<sup>66</sup> Blumberg & Nichols, see note 23.

<sup>67</sup> Smith, see note 46.

<sup>68</sup> See sources cited in notes 62, 66, and 74.

premium rates tend to drive insurers out of states.<sup>69</sup> The individual market has become unattractive but has not entered the “death spiral” predicted by reform’s harshest opponents.

The reforms embodied in the federal Health Insurance Portability and Affordability Act and Kentucky’s 1998 Act—bans on discrimination against group members, portability, limits on pre-existing condition exclusions, and guaranteed renewability—are generally popular and do not appear to have disrupted the market.<sup>70</sup> However, a detailed econometric analysis projects little if any effect on the number of persons covered under commercial insurance plans.<sup>71</sup>

With regard to cost, small group markets and managed care plans remained competitive through most of the post-reform period studied. Rate increases were modest in most employer-sponsored plans, although 1999 has seen significantly higher premiums.<sup>72</sup> States with more stringent managed care plans and wider acceptance of managed care showed lower premium rate increases. Indemnity plan premiums climbed at a significantly higher rate throughout the period studied as their market share declined and their remaining enrollees were increasingly distinguished from managed care enrollees by age, utilization patterns, and underlying health care needs. Small group reforms have not affected competition, unlike individual reforms, which have undermined the entire concept of competition in the individual market in some states.<sup>73</sup> Despite the growing chorus of quality advocates, insurers continue to compete on cost and product design rather than quality of care in competing networks.

Financial access is not the only aspect of health care access, but it is on the top of everyone’s agenda.

The mixed record of the Kentucky Health Purchasing Alliance is typical of similar efforts in other states. Even the most effective insurance purchasing cooperatives have very small market shares and have not lowered prices.<sup>74</sup> The influence of insurance agents and brokers, whose livelihood is threatened by purchasing cooperatives, seems to have undermined their ability to gain more popularity. Risk

adjustment and reinsurance mechanisms have had no perceptible effect, and are generally considered too burdensome and crude to achieve their stated goals.

Financial access is not the only aspect of health care access, but it is on the top of everyone’s agenda. A recent CBS News poll<sup>75</sup> finds that the public sees health care as the single most pressing problem that the government should address. When asked an open-ended question, 14 percent of adults surveyed said health care is the most important problem to be tackled in the coming year, and cited the problem of the uninsured as the biggest health care problem, with 18 percent listing it as their main concern. Of those choosing health care as the most important issue, 86 percent said the current situation either requires fundamental changes or a wholesale rebuilding of the system, while only 12 percent said minor changes would suffice.

Uninsured people are at least as vulnerable to serious health problems as those with health insurance, and the costs of caring for the uninsured are very likely to be paid with tax dollars. Yet merely offering uninsured Americans the opportunity to buy health insurance at market rates has not proven to be an adequate solution.<sup>76</sup> The State Children’s Health Insurance Plan legislation at least tacitly acknowledges that affordability is critical—in this case, affordability of dependent coverage. Clamping down on rate increases is not necessarily effective: managed care plans are in

<sup>69</sup> Blumberg & Nichols; Hall, cited in note 66.

<sup>70</sup> Hall, note 66.

<sup>71</sup> Hing, note 51.

<sup>72</sup> See, e.g., the following stories as reported in *American Health Line*: “CALPERS: Announces 9.7% Price Increase for Insurers,” 20 May 1999; “MA, CA Employers Brace for Big Hikes,” 23 June 1999.

<sup>73</sup> Steven Zuckerman and Shruti Rajan, “An Alternative Approach to Measuring the Effects of Insurance Market Reforms,” *Inquiry* 36.1 (1999): 44-56.

<sup>74</sup> M. Susan Marquis and S.H. Long, “Pooled Purchasing: Who Are the Players?” *Health Affairs* 18.4 (1999): 105-11.

<sup>75</sup> As reported in *American Health Line*, 15 July 1999.

<sup>76</sup> Kenneth E. Thorpe and C.S. Florence, “Why Are Workers Uninsured? Employer-sponsored Health Insurance in 1997,” *Health Affairs* 18.2 (1999): 213-8.

financial difficulties across the country, despite the widely reported multimillion dollar compensation packages for a few of the publicly traded plans' executives.<sup>77</sup>

Although the commercial insurance market was the preferred vehicle for improving health care access, cost and quality through the reform initiatives of the 1990s, its limits have become painfully obvious. Even with universal access to health insurance for the 44.3 million uninsured, we would still need to surmount other barriers such as inadequate public transportation, low provider quantity and quality in areas of the state with lower economic status, poor living conditions, interpersonal violence, and unhealthy lifestyles. Indiana's bipartisan Commission on Health Care for the Working Poor recognized the inadequacy of market-based insurance reforms in recommending subsidies to safety net providers as a necessary complement to coverage expansions.<sup>78</sup> When public sector purchasers behave like their commercial counterparts and demand competitive pricing from public hospitals, health departments, and other safety net providers, previously hidden cross-subsidies disappear, and the fiscal viability of these providers is threatened.<sup>79</sup>

Current discussions, like most incremental reforms, address politically popular aspects of health care with little attention to the lessons of the recent past about the impact of specific measures on other components of the system. Critical questions remain unanswered with regard to incremental approaches such as consumer protection, targeted subsidies, and public sector managed care initiatives:

- *Will the threat of litigation force managed care plans to abandon utilization restraints, and, in turn, drive up costs and add to the ranks of the uninsured, or will this popular measure empower consumers with little or no negative effect?*
- *Will safety net providers learn to manage under managed care, becoming more efficient and effective in the process, or will lower reimbursement and lack of state support jeopardize even core public health functions?*
- *Will families embrace the new state Children's Health Insurance Programs, or will bureaucratic requirements and the prevailing skepticism about government impair enrollment and retention?*

Kentucky's 1994 health care legislation attempted to increase the number of insured Kentuckians without adding to the state's tax burden. Some of the presumptions that might have made the 1994 act more successful, most notably federal health reform enactment, turned out to be incorrect. More recent legislative initiatives have attempted to shore up what was perceived as a dangerously impaired commercial health insurance market. The only real shift in the legislative emphasis away from the private sector has been to benefit the Commonwealth's children through the implementation of KCHIP, and that step was only taken in response to an irresistible federal funding opportunity.

Recent analyses of state insurance reform initiatives suggest that Kentucky's experience represents a familiar pattern, although our individual health insurance market has been more unstable than most.<sup>80</sup> States with long histories of generous local and statewide programs for the medically indigent, such as Minnesota and Massachusetts, have lower uninsured rates than the nation as a whole, but their success may be as much the product of stability over time as of superior policy.<sup>81</sup> The following chapters will detail leadership perspectives on the likely future before health care in Kentucky and discuss alternate approaches to health care access, cost, and quality that have been implemented by other states and localities. In the final chapters, readers are urged to consider the context—political, legislative, economic, demographic, and health care-specific—in which a pro-

<sup>77</sup> See, e.g., the following stories as reported in American Health Line: "Humana: CEO Resigns as Earnings Drop 46%," 4 Aug. 1999; "Kaiser Permanente: Drops Northeast in Wake of \$90M Loss," 21 June 1999; "Harvard Pilgrim: CEO Resigns Amid Financial Turmoil," 7 May 1999; "Health Insurers: 1998 Financial Results Mostly Troubling," 2 Apr. 1999.

<sup>78</sup> Eleanor D. Kinney, M. Tai-Seale, J.Y. Greene, R. Murray, W. Tierney, "Three Political Realities in Expanding Coverage for the Working Poor: One State's Experience," *Health Affairs* 18.4 (1999): 188-92.

<sup>79</sup> Len M. Nichols, "Health Care Quality: At What Cost?" *The Future of the Public Sector* 13 (May 1998), Washington, DC, The Urban Institute.

<sup>80</sup> Nichols, note 62.

<sup>81</sup> Hing and Jensen, note 51.

ect came to fruition, as well as the potential effects of each strategy on all three sides of the health care triangle—cost, quality, and access—in Kentucky. 🏢



## CHAPTER 4

# Leadership Perspectives on the Future of Health Care

To gain an informed perspective on the future of health care in the Commonwealth, the Kentucky Long-Term Policy Research Center and the University of Kentucky Center for Health Services Management and Research surveyed and interviewed recognized leaders in the field of health care. In both the public and private spheres, these leaders are shaping the future of health care in Kentucky. The group of key informants, many of whom were first identified for the purposes of a 1997 mail survey, includes:

- advocates on behalf of the public interest;
- payers or health insurance industry representatives;
- providers, including representatives of hospital, physician, and primary care organizations; and
- political leaders.

Those interviewed for this report represent only a sample of the state's health care leadership, which includes hundreds of individuals across the state who make health policy and lead health care organizations at the state, regional, community, and institutional levels. Prominent topics of discussion included:

- rising health care costs and their root causes;
- the unresolved dilemma of access to care;
- the demands of health care consumers;
- the importance of identifying cost drivers in the system;
- managed care;
- publicly financed health insurance;
- population health; and
- policy options and recommendations.

Broadly, we found that the focus of these interviews, which were conducted in 1998 and early 1999, changed somewhat from earlier written survey responses in 1997. Many common themes emerged. In general, the concern about dwindling access to health care—often linked to cost—that dominated responses to our 1997 written survey was eclipsed at the time of our interviews in 1998 and early 1999 by a general sense of alarm about the rising cost of health care. These observations may have been influenced by rising health insurance rates and by the release of a series of long-range health care cost projections at the national level. During the early stages of our interviewing process, some insurance rates in Kentucky were rising after a four-year cap on rates was lifted. Our interviews also coincided with the release of forecasts of future national health care costs and a number of reports on the anticipated public health care costs associated with retiring Baby Boomers.

The changing roles of those interviewed reflect the uncertainty of the health care arena to which many of these health care leaders referred. For various reasons, a number of the key informants who we interviewed are no longer serving as leaders of the organizations they headed at the time of our interviews.

We also noticed during the course of the interviewing process that the general pessimism about the future of health care in the United States and Kentucky that was evident during the early part of the interviewing phase waned somewhat. In later interviews, some expressed greater optimism about solutions to the problems associated with access to and the cost of care. Over the course of the interviews, many recommended strategies for change.

While many of those interviewed expressed reservations about the state's ability to leverage constructive change, the more optimistic and more visionary among them perceive health care as an arena where the state of Kentucky can make a significant difference. They offered many policy options, as well as visions for the direction that health care here and around the nation should take. Though the visions of these health care leaders conflicted at times, differences were largely due to the means rather than the end. Many well-reasoned, constructive ideas about how to shape a more rational delivery system and to advance health and well-being emerged from these interviews.

## Underlying Costs

The health care leaders interviewed for this report expressed fairly consistent perceptions of the scope of the problems associated with health care today. Problems associated with the cost of care, however, dominated the remarks. Both external forces, namely the demographics of an aging and growing population, and internal industry forces continue to exert upward pressure on costs, even as we appear to be moving toward widespread adoption of a managed care system that explicitly controls how much care will be delivered and thus how much cost will be incurred.

Sen. Tom Buford, Chairman of the Banking and Insurance Committee, observed, "To look to the future, you have to go into the past. Price is the problem. . . . National health care spending has climbed at least twice the general inflation rate for more than a decade. . . . The U.S. Department of Commerce expects medical spending to go up 12 to 15 percent a year over the next five years, unless significant changes are made in the health care system."

Rep. Bob Damron, an accountant, characterized the principal cost issue as a tension between the desire for high-quality and thus high-cost health care and our ability to pay. "Those [health care] costs are increasing far in advance of what the inflation rate is increasing, of what average wage levels are increasing." Dr. James Holsinger, Chancellor of the University of Kentucky (UK) Medical Center, observed that a paper he had written 15 years ago on balancing cost and quality needed only the numbers revised. "Nothing's changed," he observed. What has changed over the past 50 years, Chancellor Holsinger added, is the movement of government into the health care arena and the subsequent politicization of the issue. As a consequence, he suggested, concerns about tax burdens and public budgets, rather than the goals of health, now drive our discussions of health care.

The majority of these health care leaders believe that the health care system must be restructured; that, at some point, it will be necessary to make systemic changes to close gaps in access, contain costs, and assure more uniform quality. Ultimately, suggested Loyd Kepferle, Director of the University of Kentucky Center for Rural Health in Hazard, the current mix of public and private health care in the United States which has evolved incrementally has not yielded the desired results. "We cannot have an open market on the one hand and think we are going to have any kind of stabilization of health care costs and provision of services to the poor."

The perception of health care reform as solely an economic issue is, in the opinion of many providers we interviewed, counterproductive. Under the influence of market reforms, suggested Dr. Forrest Calico, a physician and the former president of a Kentucky network of hospitals, the U.S. health care system has deteriorated significantly, moving the nation farther and farther from the goal of population health that most of these health care leaders believe should be paramount. "All of the efforts to date that have been economically driven . . . have really not resulted in any improvement in the system at all."

Some of health care's cost drivers discussed by those interviewed have also posed new ethical dilemmas. Medical advances, observed Sen. Benny Bailey, administrator of a rural eastern Kentucky primary care clinic, have made it possible for people "to live sick longer" and have trans-

formed intensive care units, which were created to treat severe trauma, into “very expensive hospice units” where people who often have no chance of survival are kept alive at great expense. Similarly, Dr. Calico observed, “We spend . . . enormous amounts of money on terminal care when all we’re doing is inflicting pain and destroying peoples’ legacies.” George Nichols III, Commissioner of the Department of Insurance, asked rhetorically, “Why is it in this country . . . we spend the majority of money we’ll spend on you in the last three months of life?”

The high cost of medical technologies that prolong and save lives may have become more than the system can shoulder, several of those interviewed suggested. Former Kentucky Kare Director Robert Finnegan cited an example: “We keep neonates now that 12 to 15 years ago would not have survived outside the womb probably an hour . . . but the fact is, they are expensive, and we have people who come in with that expectation of care. There’s just not enough money. You can’t charge enough premium to overcome that.” Conversely, Sen. Buford noted that technology and pharmaceuticals could be expected to eliminate many costly medical conditions in the years to come, thus producing overall savings to the system.

The pursuit of lower costs, many observed, has dramatically changed the delivery of health care and not always in the best interest of the patient or the system. The continuing drive to reduce the length of hospital stays has turned hospitals into intensive care units, UK Medical Center Chancellor Holsinger suggested. “There are no walking wounded. . . . We’re going to have a heck of a time attracting people into nursing . . . there is never any downtime.” As a result, he added, nurses are “bailing out of acute-care settings” and opting for less demanding roles. Significant workforce issues lie on the horizon, he added, and recruitment has already become difficult, particularly in rural areas. As demand rises and supply wanes, compensation for nurses in hospital settings can be expected to rise and contribute further to higher health care costs.

Sen. Buford also observed that the absence of uniformity in practices drives costs up in some regions and some facilities. “There are no nationally accepted protocols for medical treatments to guide doctors and hospitals, and the fear of malpractice suits is sometimes cited as the reason doctors order unnecessary medical tests. Now these two items may not seem like great, huge cost cutters, but they are things elected officials could control—if they had the backbone to do so.”

Dan Howard, Executive Director of the Kentucky Association of Regional Programs, which represents the state’s mental health-mental retardation boards, observed that a system that simply gave an individual, “exactly what they need, when they need it” would be far cheaper than what we now have. As is, he suggested, “We force them to go through certain protocols and procedures, and we force providers to spend more dollars than they need” to align treatment with reimbursement schedules.

We have changed health care in other ways that may not be cost efficient, noted Jane Chiles, Executive Director of the Catholic Conference of Kentucky and an advocate of health care reform. Today, for example, surgeries that once routinely required a hospital stay are conducted on an outpatient basis. “Out-patient . . . supposedly gets better outcomes and is more cost effective. Well, we all can tell our horror stories of four hours in and out of a same-day surgery center, and it’s \$5,000. We really begin to question whether or not we have done anything cost-effective here. Or have we just created another little boutique in the delivery of health care?”

Representatives of insurers, as well as others, see a future that will inevitably involve more out-of-pocket expenses from the insured in the form of higher overall rates, co-insurance, and copayments. Many employer-based insurance plans no longer cover dependents and many require

“Out-patient . . . supposedly gets better outcomes and is more cost-effective. Well, we all can tell our horror stories of four hours in and out of a same-day surgery center, and it’s \$5,000. We really begin to question whether or not we have done anything cost-effective here. Or have we just created another little boutique in the delivery of health care?”

*Jane Chiles*

a larger share of the premium be borne by the employee. Jeff Johnson, the former CEO of Advantage Care and chair of the state's HMO association, reported that his firm was \$1 million over budget for pharmaceuticals alone in 1997. As a consequence of rising drug costs, insurers continue to limit access to high-cost drugs. "Almost every HMO . . . in this state has a closed formulary, and we are closing them further, ramping them down. Consumers don't like it, physicians don't like it, there's no joy in it for us, but the costs are out of control."

The absence of system planning and system thinking also continues to exert pressure on the cost of health care, many suggested. For example, many expressed the belief that the concept of an independent agency, such as the now defunct Health Policy Board, was worthy and should have been retained. Former board member and retired hospital administrator Sister Michael Leo Mulaney suggested that flaws in its planning and execution, namely the concentration of too much power without essential checks and balances and without a clear line for reporting, detracted from what was a good idea. Sen. Ernesto Scorsone concurred: "Probably the most important thing we could do right now is gather data, which was part of the reform act of 1994. Data collection was going to be an integral part of all of this, [but it] was gutted in 1996 because the providers didn't want to have to provide this information. And you still can ask the Department of Insurance basic questions of the marketplace, and they don't know."

Dr. Sheila Schuster, a psychologist, a lobbyist for the state's psychological providers and a prominent advocate of health care reform, cited an example of conclusions that are frequently drawn absent the data to prove them. "There is no data. . . . One of the things we heard [during the legislative session] was that guaranteed issue and modified community rating had driven the young healthy males out of the market . . . They don't have any way of knowing that," she said. "How can we do any planning on accessible care or affordable care when we know so little about what we're already doing?" Richard Seckel, a long-time advocate of expanded access to health care for poor Kentuckians, added, "We need good numbers on a whole lot of things." Chiles agreed, "We've got to look . . . at the costs that are driving this system. . . . In Kentucky, the closest we ever came to that was with the establishment of the Health Policy Board, but they never got out of a startup mode. . . . You can't legislate a cost-effective health delivery system. There's got to be somebody that takes full responsibility for that." Rep. Tom Burch also lamented the Board's demise, "We were beginning to pull that together in our health care reform . . . finding outcomes, what the cost was . . ." and how it varied by region.

Several of those interviewed also bemoaned what they see as the politicization of the presently inadequate process of planning for health care. The awarding of a Certificate of Need for a cardiac unit in southeastern Kentucky was criticized by a number of these health care leaders. "We have to see absolute overriding need for more facilities before we will authorize or change our formula to issue certificates of need because, when we do that, we know we are also going to increase the demand on budget requirements to fund those beds," observed Howard. Similarly, Dr. Timothy Costich, Medical Director for the Lexington-based insurer CHA, noted, "There is ample data: increasing the number of sites for heart surgery to be available doesn't move patients; it just creates a need to create need." Sen. Tim Shaughnessy also criticized the Certificate of Need award: "Don't tell me the government is the answer to regulating health care when you look at the way we just handled cardiovascular procedures in this state. How many hospitals do we have with open-heart programs?"

According to the Rural Health Center's Kepferle, several eastern Kentucky hospitals are planning for the future with such expansions in mind. "I really do think that part of our problem is this kind of competitive fetish that we have. It is leading us to try to do things that we have no right doing. . . . I really believe in the right of local decisionmaking—and the necessity, but it's like the rule of law. You are a driver, and you have to follow the rules of the road. You can't do what you want to do just because you have a car and insurance."

A number of those interviewed noted that we could anticipate higher future costs and higher demand for health care services as a consequence of the aging of our population. Former Secretary of the Cabinet for Health Services, John Morse, saw the necessity of reducing what are principally public costs. "We cannot afford to take care of this next generation of elderly in the same way that



we care for today's generation of elderly. The nursing home admission rate has absolutely got to go down." A prime cost driver for home health alternatives, observed Howard, are the limitations placed on "nonprofessional supports" in the home. "They [Medicaid] have provoked higher costs, not more reasonable costs, for assisting people to get as much health care in their home as they need to avoid higher-cost institutional placement." Ironically, changes in the Balanced Budget Act have also limited payment for some home- and community-based services for the elderly.

Numerous health care leaders also referred to the inadvisability of setting policy that runs counter to society's overriding interest in harnessing health care costs. Several of those interviewed cited legislation permitting motorcyclists with health insurance to ride without helmets as a cost driver. "All that does, as far as I'm concerned, is help the transplants of young guys on motorcycles," said Sister Michael Leo. Dr. Ken Peters, former president of the Kentucky Medical Association (KMA), which represents about 75 percent of the state's physicians, also saw the move as counterproductive. "It is a little bit difficult for me to sit here and say that our . . . legislative body acted judiciously when any layperson that I have ever talked to understands that wearing a helmet will decrease morbidity and mortality. And that's a significant cost factor." Seatbelt laws and individual choices, Dr. Peters also suggested, are an important factor in the larger picture of health care costs. "What a tragedy to spend hundreds of thousands of dollars . . . trying to rehabilitate people that are quadriplegic because they didn't put a seatbelt on. Indefensible!"

## The Access Dilemma

The majority of those interviewed for this report decried the way the U.S. health care system excludes millions from routine access to care. "We ration care in the most reprehensible manner: if you've got plenty of money, you get good care; if you don't have money, you don't get good care," Sen. Bailey observed. "While we are willing to have universal care for somebody with a heart attack, we think it's a waste of money and socialism to pay for high blood pressure medicine before the heart attack." Dr. Peters termed the current limitations on access to health care in the United States immoral and indefensible. "We are the most affluent society in the world by any criteria, and we have the most underserved of the Western nations." The problem, he observed, is not one that can be solved by any one sector alone. Instead, he suggested, it is a multi-system issue that society as a whole must address. In spite of all our efforts, the Catholic Conference's Chiles observed, the fundamental problem of access has changed little. "With the exception of those people who can now buy health insurance, we have done nothing to really bring more people into this system."

The problem, observed Kepferle, is worsening. "Because of the way insurance premiums are just skyrocketing, there are so many people who are dropping out of the insurance system." Thus, the problem of the so-called "crack" or gap in the health care system is fast becoming a chasm, he suggested. Sen. Marshall Long

concurred. "The ever-rising cost is going to make health care prohibitive to a lot of people, and I mean working people. . . . I think a lot of people are opting out of family coverage right now."

Moreover, Dr. Calico suggested, policymakers and the public have not responded. As a point of illustration, he drew a parallel with

the deregulation of the electrical industry. "If we . . . measured the success of [deregulation] by the electrical companies' becoming fabulously rich while we deprived 40 million Americans of electrical service, would we say that's a success? I don't think so . . . but that's the way we're measuring success for the health care system." The growing problem, Sen. Bailey observed, may become the impetus for systemic change. "I think we're rapidly gaining on the point where it's

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*Dr. Forrest W. Calico*

beyond people's ability to pay. Now you're getting into the masses . . . as long as we've got 54 million uninsured, we hate that, we'll talk about it in our meetings and say it's a terrible thing, but we're not motivated to do anything about it. Now, when it gets down to us, we start getting real, real interested."

Joseph Smith, Executive Director of the Kentucky Primary Care Association, suggested that by treating health as a commodity, policymakers and the public have avoided the real issue at hand. "We're very ambivalent about health care: is it a right or is it a privilege? I think that debate has to be carried out, and I think it will probably come out that we as a society say it's a right. . . . Once we establish it as a right, then we've got to start public review of the concept of rationing. . . . Rationing of health care is probably the biggest public health issue confronting this country. . . ." He added that the more citizens are confronted with financing systems rationing their health care, the stronger their interest will be in how those decisions are made. Today, insurers and employers effectively ration health care by limiting what they will or will not pay for. Ultimately, Sen. Long suggested, organized public responses will hinge on whether people want rationing determined by the government or by insurance companies.

Because we have not made these difficult choices, UK Rural Health Center Director Kepferle observed, the United States incurs much higher costs. "The countries in the world that are fairly well advanced—Canada, England, Sweden, Germany and many of them that have universal coverage—are probably paying less per unit in terms of visit than we are . . . because they have, to a certain extent, set up barriers. They have made choices." Ultimately, Howard noted, the public pays for the cost of health care for the uninsured through public safety net programs. "You're going to pay for it one way or the other."

Sen. Buford cited the Kentucky Children's Health Insurance Program (KCHIP) as "perhaps the best tool that has come so far" to help close the widening gaps in access. "Unfortunately, Kentucky did not activate it expeditiously, and we still have too many of our young uninsured," Sen. Buford observed. "I feel that government should address itself to these children's needs and perhaps we need to go beyond the 200 percent of poverty as a qualifying number. I believe that we could, as a nation, provide universal care to all children under 16." More specifically, Sen. Buford advocated universal coverage of prenatal care and the deliveries of babies to cement the association of a child's life with health coverage for children. "It might be expensive in the first few years, but your real measure of savings will come down the road, 20 or 30 years out. Prevention will cure a lot of what you would have had to deal with down the road."

Seckel viewed the events of recent years as lost opportunity and momentum. "I'm not sure Clinton had the right plan, I'm not sure Jones had the right plan, but I hated to see those things unravel . . . become business as usual," he observed. "I'm wondering what sort of swing of the pendulum . . . will lead us back to where we think globally, boldly. We had a sobering experience as far as [learning] what interest groups will fight change very hard. The insurance industry didn't really want to see control by government so they made us fear that some big government plan was going to treat us badly. . . . Now we have big insurance bureaucracies which we're starting to feel maybe aren't treating us right. I have a certain feeling of 'I told you so about that.'" The recent announcement that 44 million Americans are now uninsured coupled with new health proposals by presidential candidates may again enliven the debate.

## The Demanding "Haves"

The majority of those interviewed observed that health care costs have risen with the demands of health care consumers, who have come to expect what Sen. Bailey termed "unlimited access to universal care." Sen. Tom Buford concurred: "Americans are not accustomed to the words 'no' or 'wait.'" Dr. Costich offered a similar characterization of consumer expectations, "If you ask people what they want, it's whatever I want, whenever I want it, for free." Commissioner Nichols observed that high expectations abound throughout the system: "If I'm a doctor, reimburse me what I want to be reimbursed. If I'm a hospital, get it back up there where my real costs are. If I'm a consumer, give me everything, and I want it at a fairly low price." Ironically, Kepferle noted, the

system is most generous with its “haves” while the “have nots,” the uninsured, enjoy few buffers from the cost of health care. “The people who can better afford to have reasonable health care usually have all of the perks.”

UK Medical Center Chancellor Holsinger suggested that the inability of the system to expand access is partly an outcome of the high expectations of the insured. As a point of illustration, he related the story of a fellow medical student who had opted to change careers when faced with the ultimate price of being the best in his family’s business—crop dusting. While he was the third best crop duster in the state of Florida; the best, he told his colleagues, were dead. “You see, I don’t get the 5 percent in the corners.” That last “5 percent in the corners”—the expectation of full coverage—exact enormous costs from our health care system and ultimately limits access, Chancellor Holsinger suggested. If Americans were not “so first-dollar-coverage oriented, wanting everything paid for out of their insurance, and were willing to do copays, deductibles . . . you could remarkably change the cost end of things.”

Consumer decisions based largely on convenience, noted former KMA president Dr. Ken Peters, are also factors in the ever-rising cost of health care. An individual’s decision to seek treatment at an emergency room for convenience at a cost of “\$300 to \$500 an encounter” rather than go to his or her treating physician costs the system. “I have long been convinced that we need to retrain our society, that, if we did a better job of educating our folks and those in my profession had evening hours . . . we wouldn’t be going to the emergency room so often.”

Also part of the problem, concluded Chiles, is how removed consumers of health care are from its cost. “I think somewhere in this system, as consumers, we need to know what those costs are, but as long as you have a third-party payer system and you’re just putting in your premium and your card keeps coming back to you . . . we’re really insulated from what those costs are.” So insulated, suggests Anthem’s spokesperson, that when television news programs cover medical procedures, demand for the procedure goes up immediately. “People see it and they want it; they want it then and now. And they don’t want to have to go to a particular place to have a procedure done. They want their local hospital to deliver the procedure. They don’t want to be inconvenienced.”

The future, Chiles suggested, will demand that we revise our expectations of the health care system, particularly as Baby Boomers begin to place added stress on the system. “We have grown up in . . . this lush, plentiful environment . . . [but] employers are not going to sustain paying for what our expectations are.” Dr. Peters made similar suggestions: “Individual members have to take some responsibility . . . if people pay a little more, they’ll be more judicious. We are the most drug-oriented society, and we have got to be sensitive to the fact that somebody is paying for it.”

## Finding the Bottom Line?

Many of the health care leaders interviewed for this report contend that managing care is not enough and not the ultimate solution. “There is a legitimate concern of insurance companies playing doctor, making medical decisions in order to curb the care that people get. [But] until we can curb the cost of the care—not just the care itself . . . we are making a transition without

the bridge that leads us from one point to another, which is the money,” argued Rep. Steve Nunn. “At some point, we’ve got to reach beyond managed care and start looking at the relationship between insurance companies and providers.” The costs of specialists, hospitals, physicians, nursing homes, pharmaceuticals are, in Rep. Nunn’s

opinion, “draining the system of funds necessary to treat the broad population. . . . If you don’t control the cost within the system at the provider level, then the insurance companies are going to have to continue, in order to be profitable, to charge higher premiums. . . . To lay the blame on the

“To lay the blame on the insurance companies singly would be inappropriate. I don’t think any action from the states or the federal government dealing primarily with insurance companies is going to resolve the problem of cost.”

*Rep. Steve Nunn*

insurance companies singly would be inappropriate. I don't think any action from the states or the federal government dealing primarily with insurance companies is going to resolve the problem of cost."

Several of the leaders who were interviewed pointed to salaries, particularly for physicians and health insurance executives, as out of control. "There are . . . too many people who've got too much at stake in it, and probably, people that expect too much money," Smith observed. Within a few decades, he noted, physicians have gone from making twice the annual salary of a skilled full-time white male employee to five times as much. "Have they added that much value to that population? And they set the salary expectations for most people who are in health care. Nurse practitioners are now demanding as much as a full-degreed, full-time starting physician did three or four years ago." Retired hospital administrator Sister Michael Leo Mullaney concurred. "You want . . . the people who work in health care to have a living wage. You don't want the doctors to all be running around in Mercedes and Lexus's. . . . There are some pretty egregious examples in health care right now."

Anthem's spokesperson saw provider costs as the real issue. "We've never really dealt with the cost of care . . . We haven't really made it tougher or more restrictive on the provider side. It seems as though everything that has been done has been imposed on the HMOs." He points to a number of "provider-driven" initiatives such as the mandatory point-of-service offering, an insurance option that permits policyholders to go out of their provider network, that have been cost drivers. While such benefits are called patient or consumer protections, he suggested, they are in reality provider protections because, ultimately, the provider benefits. "We can pay for anything . . . the question is, 'What will the public pay for through premium?'"

Noting that insurance is merely a mechanism to spread the cost of health care, Rep. Damron concurred. "To deal with the escalating costs in insurance premiums, you've got to deal with the escalating costs of health care." He points to a complex web of cost drivers that insurers and providers weave for marketing and administration as well as service delivery. The more costs added to the mix, the higher premiums are. Commissioner Nichols observed that an estimated 20 percent of health care expenditures outside the public sector goes to insurers. That percentage goes to provide shareholders equity and finance marketing, claims management, administration, etc. In contrast, Sen. Bailey noted, the public cost of administration of Medicaid has been quite low, an estimated 3 percent. Thus, the estimated 17 percent difference for a trillion dollar industry could provide health care to many Americans.

Sen. Bailey also expressed frustration with the unwillingness of physicians, whose organized opposition was instrumental in winning a 1998 repeal of the provider tax, to contribute through taxes to the system that either directly or indirectly benefits them. Among other things, doctors' gross receipts were taxed to raise revenue for Medicaid. Sen. Bailey recounted meeting with a group of disgruntled northern Kentucky specialists. "They said they didn't see Medicaid patients. Well, if you are a specialist, you don't see a lot of Medicaid patients because we don't allow them to get to you. But, at the tertiary level, most physicians have to have a hospital . . . to work. When I looked at the books at that time, we were paying like \$13 million dollars in northern Kentucky for Medicaid patients' hospital care," Sen. Bailey said. "Those hospitals used that Medicaid money to buy new equipment for their operating room and to spruce up—so these specialists could make money from their paying patients. So . . . they got a tremendous benefit because . . . the hospital couldn't operate without the Medicaid money, and the hospital certainly couldn't buy brand new 'laser-gamma whatever's' if they didn't get that \$13 million from Medicaid."

## Managed Care vs. Care Management

Under their original, idealistic origins, health maintenance organizations (HMOs) focused on maintaining health through preventive care. Managed care has, in part, evolved into systematic efforts to control the consumption of health care and thus the unnecessary costs associated with overutilization. These health care leaders offer widely varying perspectives on managed care. As suggested by Chancellor Holsinger, the U.S. health care system is in the midst of structural

change—"the industrialization of health care"—that has significant social consequences. "It has been a cottage industry up until four or five years ago when we started spreading managed care across the [system]. . . . And some of the changes . . . will work fine, but it isn't going to feel the same."

Former Health Services Secretary Morse viewed managed care as "our one hope of controlling expenditures." However, the public and provider backlash against managed care has garnered significant political attention at both the state and national level. "In my opinion," said Morse, "it is far more of an issue that people don't have health insurance coverage . . . than that the people who do have health insurance coverage . . . believe it to be inappropriately inaccessible to them." Jettisoning managed care in response to irate constituents, Morse added, would be like "throwing the baby out with the bath water." Health reform advocate Dr. Schuster, however, noted that many have come to view managed care as synonymous with limitations on access. "What people translate managed care into is denial of care. That's how they experience it."

Moreover, suggested Dr. Calico, managed care's promise of lower costs has been, at best, illusory. "They say that managed care has driven down the cost of health care, but why is its percentage of the GDP [gross domestic product] going up?" In contrast, Commissioner Nichols noted, "Managed care has never been savings; managed care has been cost containment. And it has done fairly well if you look at the increases we've had."

Managed care has also added costs to the system, several leaders noted. Administrative costs for insurers—and providers—have risen as managed care has expanded. Anthem's spokesperson noted that insurers now must have more medical professionals, including physicians and nurses, on staff. "And the public has demanded that. They don't want \$6-an-hour clerks making decisions about what gets paid and what doesn't get paid." Likewise, the demands of dealing with insurers, several respondents noted, have significantly increased overhead for providers.

If the overall delivery system remains unaltered, Commissioner Nichols suggested, business savvy will become an essential provider component. The sole practitioner is becoming an anomaly as physicians find financial advantage in group practices. Moreover, provider management, he noted, has become big business.

"Younger doctors are going to become business people . . . because guess what the key to managed care is for a provider? Knowing your costs," he observed. "So they are going to get into capitation and sharing risk, and they need to know the same thing all the rest of us need to know—costs."

But managed care, much less its more advanced evolutionary forms, has yet to penetrate much of the state. "Kentucky has never really had real managed care like you find in some of

the more progressive states and cities in this country," observed Commissioner Nichols. "We've never gotten there because it's not something we've ever been comfortable with, and . . . when we get comfortable, we don't move that quickly." Additionally, a number of those interviewed discussed the difficulty of moving managed care into rural areas where the base of providers and patients is insufficient to negotiate lower rates. Managed care, it was noted, works well in locales with excess capacity where insurers have bargaining power.

Physicians and provider representatives viewed the health insurance industry, particularly managed care payers, as the primary health care problem we face and as the new cost driver. Dr. Phil Hulsman, a retired obstetrician and a spokesperson for the American Association of Retired Persons, suggested a new beneficiary of cost excesses, "The idea of HMOs to cut down on costs of medicine was a good idea. However, we find now that the affordability has not really changed that much. The health dollar has gotten into a different pocket, and that pocket is the people who run

"The idea of HMOs to cut down on costs of medicine was a good idea. However, we find now that the affordability has not really changed that much. The health dollar has gotten into a different pocket, and that pocket is the people who run HMOs. . . . They're taking home million dollar salaries, and, I feel, at the cost of care of the patients."

*Dr. Phil Hulsman*

HMOs. . . . They're taking home million dollar salaries, and, I feel, at the cost of care of the patients. . . . We're seeing more and more stories of patients who have been physically deprived of care."

The KMA's Dr. Peters saw managed care as the driving issue. "I think, short term, the number one issue on everybody's mind today, regardless of your age, gender or status in our society, is managing our health care resources and getting some . . . or all or most of the decisionmaking back to the doctor-patient relationship. . . . Any barrier or impediment to that relationship in the decisionmaking is unacceptable." He strongly advocated passage of legislation that would permit individuals to sue their health insurers in the event of denials of benefits that adversely affected their health. "Only two segments of our whole society . . . have immunity [from lawsuits]: foreign diplomats and HMO bureaucrats."

For those with even minor mental illnesses, mental retardation, or substance abuse problems, Howard suggested, insurance companies have created obstacles to the care they need to remain healthy and, in some cases, to function. "The insurance companies discriminated for a long time in treating mental illness differently . . . they set limits on how many visits a person could get, and they set lifetime caps on how much they would spend on treating a mental illness; whereas, they don't necessarily have the same kind of caps on physical illness."

Once the darlings of Wall Street, some managed care entities have also experienced diminished profits and losses in recent years, partly as a result of competitive zeal to capture market share. Sen. Richard Roeding, a registered pharmacist and former lobbyist for the pharmaceutical industry, suggested that the limits of managed care's ability to control costs are being reached. "Managed care saves money down to a point, then it levels off and . . . goes back up. And that's why managed care companies are losing out. . . . You can only squeeze so much out of rates."

UK Medical Center's Chancellor Holsinger sees the lure of profit in the health care industry fading. "We're all, I suspect, going to start seeing the for-profits get out of the business because I don't think they are going to be making a profit. . . . The for-profit managed care companies cannot keep driving the bargains down to the place where you can't cover costs. There aren't going to be any hospitals or health care providers to provide health care . . . We are a not-for-profit organization, but if you are driving those kind of bargains with for-profits, then there aren't any profits, and then you begin to see the whole thing snowball out of control. And we are seeing that."

## Insurance Reform and Retreat

Not surprisingly, those interviewed for this report offered widely differing perspectives on the efforts of the General Assembly to expand access by reforming Kentucky's individual insurance market. Many strongly favored the reform package adopted by the General Assembly in 1994, others strongly opposed it, and still others disagreed with selective provisions. In many cases, however, leaders with differing perspectives shared common views on why the reforms met with certain outcomes.

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*Commissioner George Nichols III*

Dr. Costich's observations about Kentucky's most recent health reforms were shared by many of those interviewed for this report, regardless of their position on the reforms. "We have a system where people either get health care through a mandated entitlement, Medicaid [or Medicare], or they get it through a self-insured employer, over which there is absolutely no control, oversight, or anything, or they get it through a commercial plan from their employer. And there is this very small group of people who are individually insured. We spent an awful lot of time last legislative session talking about those people, but they are an amazingly small minority."

Indeed, Commissioner Nichols questioned the rationale behind focusing on insurance as a means to broadening access to health care. "Is health care a right or a privilege? Once you answer

that question, what does insurance coverage have to do with it? . . . They are not connected. Insurance is financing. It is not delivery.” The changes wrought by the 1994 reform package and subsequent retreats, suggested Commissioner Nichols, effectively traumatized the industry, abruptly putting an end to its “worst habits.” Prior to the reforms, he added, “There were levels of competition; there was never competition to Blue Cross [Anthem].” The net effect of the give-and-take approach to reform has been to “feed the gorilla,” to make the so-called “Blues” more powerful than ever before.

Former insurance CEO Johnson reported that every HMO in the state lost money in 1997. “That whole process . . . the attack on carriers in the state and just the bastardization of the market that has gone on by the legislature overreaching, mandating benefits, changing the playing rules almost annually, has really messed up this market. I have never seen a market so messed up.”

Perhaps more damaging, suggested reform advocate Seckel, has been the impact on individuals who, for a time, could secure insurance at affordable rates. “We changed the rules back to where their age is going to count against them, their health status is going to count against them. That means that if they want to buy health insurance individually, it will be very expensive to them. They don’t have disposable income since they may not be working full-time. . . . The younger family in the low-wage job and the older person who may have a health problem and who may not be in a secure job position . . . both those constituencies are vulnerable now.”

Sen. Tim Shaughnessy, a Vice President of Jewish Hospital in Louisville, also expressed dismay with the outcome of state efforts to reform health care. “Nobody has followed us. . . . I have yet to read one national publication that says, ‘Do what Kentucky did.’” While the reforms were well-intentioned and ahead of the national curve on such issues as pre-existing conditions, guaranteed issue, and affordability, he observed, they were nevertheless disastrous in their effects on the individual market. “Right now, the most important issue that we have in health care is affordability, but . . . it’s no longer a question of getting health insurance to the uninsured; it is now getting affordable, quality health insurance to people that had affordable, quality health insurance just a few years ago.” In contrast, Sen. Scorsone sees the retrenchment from reform as a national movement. “Everybody’s backpedaled, not to the extent that we have . . . but to a certain degree.”

Sen. Long’s perspective on reform differed significantly from Sen. Shaughnessy’s. The insurance industry, he and many others argued, made an example of Kentucky “because we are a small state, and it really doesn’t hurt their bottom line much. So they determined to punish us as much as they could. But you’ve got to remember all those people that pulled out insured less than 10 percent of the people—and they were healthy people. They didn’t insure sick people. . . . Competition in the insurance industry doesn’t necessarily mean that you’ve got a good deal.” Indeed, it was suggested, dealing with two to four representatives of major insurers may be far more manageable than dealing with dozens.

Sen. Bailey leveled much of the blame for repeals of the 1994 reforms on the way the news media reported on the departure of insurers from the state’s individual market. “If the press hadn’t reported it, nobody would have known . . . except the opponents of health care reform—the insurance companies. . . . The individual market didn’t exist in 1990. . . . They weren’t competing for 95 percent of the insurance in this state. They were competing for the healthy individuals who had to promise they would never use insurance before they would sell them any.”

More specifically, Humana spokesperson John McCarthy believed the reforms went one step too far. “They could have gone to guaranteed issue, portability and renewability and kept it at that, but when they went to modified community rating in addition, it didn’t work. That’s what drove all the carriers away.” The combination of guaranteeing access to insurance and controlling what

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*Sen. Benny Bailey*

insurers can charge will not work, McCarthy argued. “It . . . forces out the young and then it does benefit the few that are sick, but there’s far more people that are healthy . . . that drop out of the system.”

Sen. Roeding asserted that he had opposed “every piece of health care reform legislation that there has ever been in Kentucky since I’ve been here . . . because I knew it wouldn’t work, and now they’re finding out that it won’t. . . . It was just an attempt to continue towards a one-payer system in Kentucky [which is] about what we’ve got now because the whole insurance industry left us.” The issue, in Sen. Roeding’s opinion, should be viewed as an economic development matter. “If we want to bring a company into Kentucky to locate their plant or their operations here, we . . . give them everything that they asked for. Yet here, the insurance industry was telling us, ‘You can’t do this . . .’ and we did it anyway.” As a result, he adds, Kentuckians are paying far higher insurance rates than ratepayers in other states, and fewer Kentuckians can afford health insurance.

However, D.J. Wasson, Principal Assistant to Insurance Commissioner George Nichols III, reported that so many variables affect health insurance rates that state-to-state comparisons are difficult to make and usually unreliable. The factors that affect health insurance rates include, to name a few, mandated benefits, copayments, rating methodology (i.e., some states do not allow rating based on health status), and “guaranteed issue,” a Kentucky requirement that may have as much as a 10 percent impact on rates, according to Wasson. “For these reasons, we have never been able to gather a rate comparison among states.”

An advocate of the insurance reforms, the Catholic Conference’s Chiles observed, “I think the individual market was where you had your biggest quality problem with health insurance products, with some really crummy policies out there, and I am grateful that those companies have left this state. I hope that what we have in place now is sufficient to keep them from coming back.” She added that the remaining consumer protections would become increasingly important. “They say the managed care companies have done about all the squeezing of their costs as they possibly can, and so for them to continue to keep their financial position where it is, they are now going to have to take it to another level, which means more denial of patient care . . . in order for the HMOs to hold their financial position.”

Rep. Tom Burch, also an advocate of reform, lamented the repeal of standard plans. “We mandated certain things in our standard plans that they used to play around with. Have you ever bought health care insurance from an independent agent? They . . . have all these big books and, it’s like you are in church on Sunday, and they flip the Bible open. We had four standard plans, and every one of them was [great]. They said we made them too rich, so now we’ve got one standard plan.”

Many of the health care leaders interviewed for this report expressed the belief that community rating is a regulatory response to the insurance marketplace worthy of adoption. Most, however, observed that a small state like Kentucky with a relatively poor population may not have been the right place to adopt it. “Community rating has been around for 20 years or more, and community rating works if it’s a big enough community,” former Kentucky State Director Finnegan observed. In the opinion of many, including Rep. Bob DeWeese, a physician who, along with Rep. Damron, sponsored legislation establishing the subsidized high-risk pool, Kentucky does not have a sufficient number of people to make community rating work. “We would have to have a huge regional entity, and it would have to be done on a federal level. We’ve seen what happens when you try to do it locally.” Others, however, noted that Blue Cross-Blue Shield, now Anthem, worked successfully within the regulatory context of community rating for many years. Commissioner Nichols suggested, “I think community rating would have had a very, very difficult time working under the structure it was presented in. The only way community rating works is that everybody in the community is in it.”

Sen. Bailey offered an anecdote about a conversation with the representative of an insurer as a way of illustrating how something closely akin to community rating works for insurers but not for their customers. “He said they had different pods . . . all kinds of little companies, and I said, ‘What do you do if you have one company that has a bad experience? . . . How do you charge



\$1,200 a month for insurance?’ ‘Oh, we don’t do that,’ he said. ‘We raise everybody a little bit to care for this company.’ That’s what modified community rating is! ‘Why are you against it?’ I asked. ‘Well, that’s what causes rates to go up.’” In the absence of a mechanism to spread risk over diverse populations, all are vulnerable, Sen. Bailey observed. “Everybody in Kentucky, in America today, is one diagnosis away from a high-risk group.”

Contrary to many assumptions about the benefits of competition among providers of health insurance, Sen. Long suggested that the state might, in fact, be better off with only a single insurer that could spread the risk over the full population. “Competition in the insurance business doesn’t necessarily mean that you’ve got a good deal. If we had 50 insurance companies and they split the business evenly, the rates are going to be . . . huge because they don’t have enough of a population.” Similarly, Anthem’s spokesperson, who decried the absence of competition in the Kentucky individual market, observed that insurers cannot remain competitive with a customer base comprised solely of a portion of the Kentucky population. “The issue for us is achieving the size and the base needed to remain a competitive player.”

Rep. Nunn found fault, not with the reforms enacted, but with their execution. “What we did do legislatively was not followed through by the executive branch. I think there is legitimate documentation that after the bill was passed . . . things went through the motions without any real, hard oversight by the executive branch. And many of these issues could have been adjusted or realigned if we had been on top of it as well as we should have been.” Sen. Scorsone saw a similar disconnect between legislative intent and executive follow-through: “There’s a bitter taste in legislators’ mouths over the reform and the backlash. . . . The legislature cannot pull this off without executive cooperation.” The health reforms of 1994 were shaped by the legislature when the governor failed to gain sufficient support for his reform package, Sen. Scorsone observed. The executive branch never really bought into them, and when a new governor was elected, they became “an orphan.”

A number of those interviewed also voiced the opinion that inadequate expertise undermined many reforms. “When we first started doing reform, not only did we not have data, we didn’t have health actuaries working for the Department of Insurance. The only actuary they had was somebody who had a background in something totally different. We were not equipped and neither was the Health Purchasing Alliance to really bargain with the insurance companies,” observed Sen. Scorsone.

Several health care leaders criticized the Health Purchasing Alliance harshly, particularly payers who reported years of wrangling. “The health plans that participated . . . just ran into hassle after hassle after hassle,” observed a spokesperson for Anthem. The problem? “Getting the premium that was due us. We are still arguing, and the Health Purchasing Alliance will acknowledge they never reconciled their records. . . . It was a complete failure.” The contractor chosen to manage the Alliance, one health care leader suggested, simply did not have the expertise to staff and manage the operation effectively.

Representatives of payers like Dr. Costich pointed to flaws in the current regulatory framework as cost drivers. Rather than designing a more efficient system, the current piecemeal approach to reform by way of mandates merely fosters an entitlement mentality, Dr. Costich suggested, without providing the money to pay for it. He finds the current “any willing provider” requirement most objectionable because, he argues, it encourages physicians and other providers to generate revenue from the same patient load. “It’s a perverse system right now. The more you do, the more money you get . . . so what you do isn’t based on what the patient necessarily needs . . . it’s based on whether you’ve got an empty slot on the operating schedule. It’s unfortunate, but it’s true.” If insurers could limit the providers they contract with to a number commensurate with their patient

“It’s a perverse system right now. The more you do, the more money you get . . . so what you do isn’t based on what the patient necessarily needs . . . it’s based on whether you’ve got an empty slot on the operating schedule. It’s unfortunate, but it’s true.”

*Dr. Tim Costich*

load and negotiate price based on that volume, physicians would have a guaranteed revenue stream and incentive to take care of the needs of those patients. Instead, he observes, “We seem to be multiplying these . . . very expensive entities that provide medical services.” Commissioner Nichols concurred, “Managed care is the ability to get a smaller network of doctors and drive the volume to you; any willing provider goes in the opposite direction.”

Conversely, Sen. Roeding defined the “any willing provider” requirement as “an anti-monopoly clause” that effectively prevents the concentration of medical services in the hands of a few providers. Dr. Schuster, who, along with Chiles, has been the state’s most prominent advocate of health care reform, views this provision as an essential consumer protection that prevents insurers from dropping selected providers based solely on costs that are linked to how much time and service they dedicate to each patient.

Dr. Costich, CHA Medical Director, also finds problems with the rationale behind segregating high-cost people and paying for their care with funds from a tax on health insurers, the net effect of the General Assembly’s establishment of a high-risk pool. “I don’t think they [insurers] eat that. I think they pass it on in the premiums.” In effect, it becomes a tax on state-regulated health insurance premiums, thus spreading the cost of acutely ill individuals over a larger community of ratepayers and achieving virtually the same effect as community rating. Only the packaging is different. Self-insured employers escape these assessments because of their exemption from state regulation.

To gain approval of a rate increase, insurers were subject to a review process (repealed in 1998) that was sharply criticized by payers. Former insurance CEO Johnson cited an example of how it increases costs. “Our actuary, the Department of Insurance’s actuary, and the Attorney General’s actuaries, all agreed that our rate proposal . . . was reasonable and appropriate. Still, he added, it was necessary for the insurance company he headed to bring expensive experts in for testimony at a five-hour hearing. “So we spent in preparation and conducting that rate hearing over \$25,000 for something everybody agreed ought to be done.” Humana’s McCarthy recounted a similarly frustrating situation in 1998. “The Attorney General’s person, actuary, says our rates are way too high; the Department of Insurance tells us our rates are too low; we think our rates are just right or else we wouldn’t have filed them that way. So, who is the final sayer in that?”

Further insurance legislation, however, is precisely what most of those interviewed viewed as the worst possible next step. For example, former insurance CEO Johnson observed, “We just need the legislature to leave us alone, let us compete in the market, have some respect for the market and the fact that employers define the market, define what they want, and what they are willing to pay for.” McCarthy offered a slightly different perspective, “They ought to let doctors be doctors and insurance companies be insurance companies and let the two work out their differences without governmental interference because . . . if our mission is the improvement of the health of our members . . . we’re out for the same goal. We have to start realizing that we’re on the same team and we can work together.”

Rep. Nunn concluded, “At this point, I think Kentucky needs to just let the market settle. And in a year, let’s look and see where we are, see if any companies have come back into the marketplace.”

Though he sees states rising to the call for managed care consumer protection, Rep. Damron thinks the variability of protections will ultimately beg federal action. “While I am a strong proponent of states’ rights,” he observed, “there probably are going to have to be some standards established in Washington to try to bring uniformity into the process.”

## Publicly Financed Health Insurance

While a number of respondents were highly critical of overregulation of health insurance, none suggested that government should get out of the business of health care altogether. From Sen. Long's perspective, government clearly has a role. "You hear, particularly at election time ... government ought to get out of health care. Well, the government is the biggest single buyer of health care in the state." Indeed, observed Bob Gray of the Attorney General's Office, the trend of many years has been one of "socializing the cost of health care while privatizing the profit."

Many who were interviewed believe that the adoption of private sector cost-control mechanisms, namely managed care, by the major government-run health insurance programs, Medicaid and Medicare, could create significant disruptions and even add costs. Many provider representatives anticipated future gaps in revenues that could ultimately force the closure of some hospitals and clinics. Kentucky Primary Care Association Director Smith, for example, foresees potential shortfalls for the principally rural providers he represents as the state adopts reimbursement rates that are below actual costs. Consequently, he and many others expressed fears that the quality and the quantity of services to both poor Medicaid recipients and to the uninsured will be undermined.

"Both Medicaid and Medicare have historically tended to micro-manage the health care system and not very successfully either from the perspective of costs or from patient care."

*Joseph Smith*

"Both Medicaid and Medicare have historically tended to micro-manage the health care system and not very successfully either from the perspective of costs or from patient care," Smith observed. "It is my belief that the state has for a long time controlled access to Medicaid by limiting and making complicated the access points in the process." In addition to its historic inaccessibility, Smith added, "There's a general feeling that a lot of people . . . who lost their eligibility for AFDC . . . weren't counseled in that process of determination on how to retain their eligibility for Medicaid."

Seckel, an advocate for the poor, added, "Even when we 'succeed' in welfare reform, we're creating low-wage workers and for a period of time, we're offering health coverage as a transitional measure in a kind of patchwork quilt way. . . . We really need to think through the circumstances of low-wage working people. . . . If we're going through a transition and we're investing less in welfare benefits, maybe the right thing to do is invest some of the savings, for instance, in making sure that low-wage working people have benefits like you or I do."

But Smith suspects the fear of possible consequences keeps policymakers from acting. "I think one of Medicaid's fears is that, were they to open up the eligibility process, both in terms of location and simplifying the process, it may be a budget buster." Another interview subject noted that a high-level state health official had expressed just such objections to organized efforts to bring more people into the system.

However, blocking access to health care also carries a higher long-term cost, many of these health care leaders asserted, one that will ultimately be borne by taxpayers. In Appalachia, for example, UK Rural Health Center Director Kepferle pointed to rates of breast and cervical cancer rates that are equivalent to the national average for incidence but much higher in regard to mortality "because people are waiting longer to get into the system. . . . That costs the system more—one lost person and that person's productivity. Too, probably the last days, or weeks, or months of their life, in terms of health care dollars, [costs] were much greater than they would have been had they had preventive services."

The process would be far more open, several leaders suggested, were the stigma of applying for Medicaid removed. Smith observed, "It doesn't have to be a demeaning process; it could be a successful service for all." Former Kentucky Care Director Finnegan added that Medicaid should be an "invisible provider." "A person should have the opportunity to go to the doctor and be treated just like anybody else—not as a second-class citizen."

Mental health advocate Howard added that preventing managed care from becoming “a vehicle to do away with the safety net system” was critically important. The promise of savings from low-bid mental health providers, he suggested, may cost taxpayers a lot more in the long run as barriers to care frustrate and complicate the treatment process, increase costs to the individual and the system, and almost guarantee poorer outcomes. “In the process, they’ll be creating a pool of people that will end up filling Eastern State Hospital back up to 2,200 people again. Ultimately, the public will pay more. That’s the cycle that can happen.”

Many of those interviewed expressed deep concern about the consequences of market reforms that have cut reimbursements and thus undermined the capacity of some providers. Nancy Galvagni, Vice President of the Kentucky Hospital Association, estimated that between 40 to 50 percent of hospital patients are either covered by Medicare or Medicaid. “In some rural areas . . . you’re probably looking at upwards of 70 percent [of patient care] or so governed by governmental programs,” Galvagni observed. The movement to managed care, she added, will simply raise fiscal pressures. “We haven’t really seen much activity in Kentucky, but we feel like that’s going to come down the road and that’s going to mean even further cuts.”

As a result, hospitals, which have historically dominated the health care system, are faced with redefining their roles. Chiles, who lobbies on behalf of the state’s Catholic-owned hospitals, expects significant change ahead. “I think the hospitals are struggling . . . with really figuring out what their mission is because at the same time that physicians and other health care providers are expecting them to constantly retool for all of the wonderful technology that becomes available, your payment mechanism, your insurers and employers, on the other hand, are saying, ‘You can go any place but a hospital.’”

## Population Health

Perhaps the most significant recurring theme among those interviewed was the need to shift the focus of health care, to turn it “upside down,” as Sister Michael Leo suggested, away from intervention to prevention, to improving population health. “When you start asking how can you control health care costs,” Sister Michael Leo observed, “it totally depends, first of all, on the condition of the patient, so you go way back to education and lifestyles.”

Higher rates of cost increases have returned to haunt us, suggested Dr. Calico, because we haven’t addressed the real issues. “We haven’t included everybody. We haven’t focused on health.

“Go to any nursing home . . . and who’s in there? Women. What were they doing when they were 20, 30, 40, and 50 that they might have been able to do differently, that would have kept them out longer?”

*Commissioner Rice Leach*

Instead, we’ve continued to focus on the profit. . . .

The way we run health care today is analogous to the resolution of a serious traffic problem. Let’s say we have an intersection where there are lots of accidents with fatalities. We would resolve that problem by putting a body shop on one corner and a trauma hospital on the other, as opposed to doing something to try to prevent the accidents.”

Dr. Rice Leach, Commissioner of Public Health, who views his role as one of protecting the health of all of Kentucky’s “4 million patients,” echoed the same sentiment. “In our system, you’ve got to be broke

before we fix you. We take better care of the equipment in a hospital than we do the people working in a hospital.” In particular, Dr. Leach pointed to the need to collect far more data to learn about the root causes that erode population health. “Go to any nursing home . . . and who’s in there? Women. What were they doing when they were 20, 30, 40, and 50 that they might have been able to do differently, that would have kept them out longer?” As is, Dr. Leach observed, we are collecting data and making policy decisions based upon when things break. “I think the least understood and biggest problem that will come to face us fairly soon is the lack of good solid information upon which to base policy.” That information gap, he suggested, will create a particu-

larly costly void as the population ages. “Just what are we doing to try to keep the boomers from going down the same degenerative path that our parents did?” he asked rhetorically. “Zip.”

The principal threats to the health of Kentuckians, from Dr. Leach’s perspective, are societal ills that take a destructive and costly health toll. Violence in all its manifestations, he observed, comes first to mind. “I think the biggest public health problem in our state is this tendency to beat up on each other. . . . We are . . . consuming the seed corn of our society.” Medical students, he added, traditionally have not been taught about how to identify and respond to family violence, and thus prevent its damaging physical and emotional consequences.

To reorient the system, however, Sister Michael Leo observed, will require a significant cost outlay on the front end. Galvagni suggested that hospitals as well as other providers need incentives to assume greater responsibility for population health. “Many of them are looking at setting up their own insurance plans, to give them the total dollars and let them manage care. . . . The insurance companies haven’t managed care that well. What they’ve done is take . . . their profit . . . then cut everybody’s rates. They’re not paying for education, prevention, immunization, or anything else.”

Chancellor Holsinger echoed a similar sentiment. “It has not been managed care, it has been managed dollars. What’s going to happen is we are going to get out of managing the dollars and start managing the patient’s care, and once we start really getting to the care end of it, I think . . . that will help to keep costs from going up as dramatically.”

Improving population health, many of these advocates suggested, will require more investment in our public health infrastructure and a strategic effort to educate, inform, and motivate the populace to make more sound behavioral and lifestyle choices. Kepferle recommended, “We should intersperse and interlace all of our education process with health promotion and disease prevention. . . . Health care is a personal responsibility, but it is also a public responsibility.”

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*Lloyd Kepferle*

Humana, McCarthy reported, is actively working to improve population health by contributing to Teens Against Tobacco Use.

“We understand that the economy of Kentucky has a lot to do with tobacco use. At the same time, the health of Kentuckians has to be looked at as well. People have to make personal decisions. The more we can educate people about the ramifications of their choice, the better.”

## The Next Step?

These health care leaders evidenced varying degrees of optimism about the capacity of the system to change. Many suggested that we must first reckon with the question of values, with the moral framework of health care. Others suggested that we need only to muster the political will and assemble the expertise to begin fashioning workable solutions. Several respondents expressed the belief that a public backlash is imminent while some suggested that the discomfort citizens feel is far from being acute enough to shift the status quo. However, most agreed that the most formidable obstacle to solutions is the array of powerful interests with a financial stake in the status quo. Importantly, to avoid having to revisit the issue continually and ensure preferred outcomes over the long term, many respondents recommended substantive policy changes.

**The Question of Values.** Several of those interviewed noted that it will be necessary to resolve some of the central questions at issue before we can move forward. “Health care is at its core an ethical issue,” Dr. Calico observed. “The dollars have to be a peripheral issue.” UK Medical Center’s Chancellor Holsinger viewed the unresolved ethical issues as central to unraveling the access dilemma. “We went through periods of time in our history . . . where it seemed like whatever we wanted to do, there was unlimited money to do it with. . . . We find out that’s really not

the case. . . . As you begin to look at that, how do you balance these ethical issues? Does somebody get a second liver transplant? There are still kids without immunizations. How do you balance the good of the whole against the good of the individual? There are tremendous health care ethical issues that we have not even remotely begun to talk about.”

Presently missing from our decisionmaking process, Sen. Scorsone added, is a “values framework” to guide health care decisionmaking. “What we don’t have is an honest and open discussion about how we should prioritize our health care dollars. . . . It’s not who has to pay, but under what conditions will they pay? We already know we’re not going to be able to fund all the services for everybody, and so, if we have a limited amount of money, which we do, then what’s the priority as to how we spend the money?”

While some public reckoning with the issues at hand will likely be necessary through the elective process, Dr. Peters of the KMA believes that leadership is key. “I think we’ve got to get some folks in the legislature . . . to stop and think that it is their day . . . and we have an opportunity to meet a human need. We need to move beyond the political connotations and do what is right and quit worrying about reelections. If you do what’s right, [you’ll] get reelected. We need some statesmanship, some leadership.”

Ultimately, the public cost of health care will compel a reckoning, several health care leaders noted. From the cost of health insurance for state employees to ever-rising Medicaid costs to expanding the state’s current mechanism for offsetting insurer’s costs for the care of high-cost conditions, current trends suggest that health care will carve an ever wider wedge of the public pie at both the state and federal levels. For example, Rep. DeWeese said, the state cannot expand coverage for high-cost conditions without considering where the additional revenue will come from. “We have to be honest and tell the people that they are going to have to pay for it through a tax increase. Is that going to be what the public wants? I don’t think so.”

Sister Michael Leo observed that the need for health care will always exist. How we deliver it is the crux of the issue. “People are always going to be sick. You have accidents, illnesses and all, or we’d last forever. We’ve got to find a way to do it economically. To me, that’s health care reform. And we’ve got to have a continuum of care that’s logical.”

**Information, Expertise and Vision.** Health policy, many of these health care leaders asserted, cannot be shaped in a vacuum. It must be informed by reliable data and advanced by individuals with the expertise and experience to shape efficient, logical systems. As previously noted, several of those interviewed regretted the demise of the Health Policy Board. With such a policy entity, many suggested, we can learn more about root causes that influence cost, quality, and access, the measurable effect of insurance regulatory provisions, health care outcomes, the progress of population health, and the impact of health education and information campaigns. Moreover, we can identify exemplars and model practices after them. Many pointed to our readiness to legislate by anecdote as a substantial weakness that can only be corrected by systematic data collection and analysis.

Other states as Indiana, Finnegan noted, have sought guidance from advisory panels comprised of experienced health care providers. “Bring people in who have some experience with this issue, and we can manage the costs,” he asserted. “I can guarantee this, if you go to major employers, including the state payers, how many of them . . . ever sat down with physicians and hospital people, sat around the table and said, ‘Here’s our benefit plan. What do you think?’” Having worked in managed care since its inception, Finnegan reported having witnessed the development of successful state-level delivery systems in comparably rural states such as Minnesota and Indiana, which both have smaller uninsured populations than Kentucky.

Commissioner Nichols noted that past efforts to collect information from insurance claims merely provided more detail about how much, rather than getting at the “why” behind costs. “We are not collecting information about costs associated with delivery systems. . . . I think we need to have the provider communities lead the effort of evaluating costs savings potential in the delivery system because you do not want to forego quality.”

Reform advocate Dr. Schuster observed that most of the expertise associated with marketing a product and managing costs lies with the private sector. “I trust the motives of government, but I’m not so sure that they . . . have the expertise that the private sector does to get the product and the services out there.” Solutions, she suggested, may ultimately involve meshing the motives of the public sector “to serve people” with the expertise of the private sector.

Dr. Leach saw the potential for the emergence of an information-based health care system or business. “The day somebody in my line of work, private or public, comes up with a way to capture some of that \$120 billion at a reduced cost—without jerking the patient around—those guys are going to get beaucoup dollars to build any information system and buy any hardware they need if they can . . . make a profit on the investment over time,” he speculated. “Look at the business world. It is leaned out, but education, law, and health haven’t yet.” Already, however, the health care industry is becoming more and more vertically integrated, as major hospitals and other entities develop insurance products, purchase physician practices and nursing homes, and create integrated delivery systems.

Above all, Sen. Scorsone emphasized the importance of developing and adhering to a coherent policy. “The most compelling thing for state government is to have a consistent health care policy. . . . a framework, a vision as to where we’re going with health care [and] . . . the various elements of state government need to be working in a consistent fashion towards that goal.”

**Untapped Market Clout.** Sen. Scorsone and several others emphasized the importance of exercising the state’s considerable clout in the marketplace. Through Medicaid, the Personnel Cabinet, which oversees benefits to state employees, and the Department of Insurance, which regulates insurance, as well as through its links to municipal, county, school, and university systems, “The state is a big purchaser of health care . . . and [it] ought to be leveraging that purchasing power to accomplish something. We don’t seem to be doing that.” If, for example, we believe that managed care offers the Commonwealth the best possible means of controlling costs and optimizing health, he suggested, we should restrict plans to this type of coverage.

From Sen. Scorsone’s perspective, the state has two options. “One is to emphasize its regulator role and to try to transform the marketplace into either a friendlier marketplace or one where access is easier . . . or look at its purchasing power as a player in the marketplace and use that role to leverage and get something done.”

Given the political climate in Kentucky, he saw the latter role as the avenue most likely to gain widespread support and yield success. In some states, Sen. Scorsone explained, government has joined with major employers to begin a dialogue about “common denominators,” about how the products they buy compare, and to leverage more coverage for less money. “Kentucky can be in the driver’s seat, if it wants to be. . . . There’s a tremendous amount of clout . . . when you’re buying health care for 700,000 people. If we used it smartly—what we’re not doing—we would have leverage with any insurance company and certainly any network of providers in the Commonwealth.” California, for example, has numerous examples of coalitions of businesses and public sector entities like the Public Employees Retirement System that have used the breadth of their customer base to negotiate lower rates and higher quality services. More recently, however, California has experienced much higher rates of increase and provider bankruptcies.

In the same vein, many of those interviewed favored a purchasing alliance to secure more affordable health insurance for individuals and small businesses. “I think there was value and logic behind creating the Health Purchasing Alliance and allowing individuals to buy coverage with the group rates that state employees would have, or universities, or cities, or counties,” Rep. Nunn

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*Sen. Ernesto Scorsone*

observed. Former Kentucky Kare Director Finnegan concurred. “The idea of group purchasing as a way of getting people into it was good,” but he added that past mistakes have affected the state’s ability to respond. “We just didn’t do the homework. Good idea, poor executors. . . . It didn’t work—not because the idea wasn’t any good—but because it wasn’t set up right.” As previously noted, representatives of health insurers consistently reported that the execution was poor.

The challenge, Finnegan suggested, is one of marshaling sufficient experience and expertise, not of paying for it. “We [the state] are the largest purchaser of health care in the state. . . . Right now, we’re paying retail.” The state, he suggested, could save millions on pharmaceuticals alone by employing a pharmaceutical management firm to negotiate price and monitor drug utilization patterns.

The many vested interests of the current system, however, will continue to obstruct change. Dr. Costich of CHA observed, “If you could just scrap the whole system and develop an efficient delivery system and not worry about whose ox gets gored, you could do all sorts of things, but that’s not going to happen. So it is going to have to be, to some extent, evolutionary.” The circumstances that affect any business, suggested Rep. DeWeese, are multiplied over and over again throughout the health care industry. “Everything that you’re going to do . . . you’re stepping on somebody’s pocketbooks . . . you see the halls and the legislature lined with interest groups, and that’s their right to do that.”

**Raising Consumer Awareness.** Some health care leaders suggested that consumer information should also become readily available to inform and empower purchasers of health insurance and health care. As an exemplar, Humana’s McCarthy pointed to Texas, what he terms “the most regulated state in the country.” There, the Texas Public Insurance Counsel, an independent agency that represents consumer interests in rate hearings and other venues, collects and disseminates information about the performance of insurers. “They actually take a random sample of your data, of your members, and do their own tests . . . and they come out with a report card.”

But, Galvagni suggested, the data must be reliable. “We had HCFA put out mortality data years ago that was not age adjusted. You don’t want something like that out there to confuse the public, but we understand that there needs to be more information.” Galvagni added, “We’re looking at a variety of ways to try to . . . have patients more involved in their care.” In fact, she added, some HMOs are beginning to require hospitals to provide patient education about in-hospital procedures and options. “If you start to involve patients . . . maybe they’ll use the system better.”

Part of the problem of unmet health care need, suggested Dr. Schuster, is that too few people without insurance are informed about the scope of public health services available at the community level. “I think we need to make better use of the kinds of services that are provided by the health departments. . . . There are real resources that people don’t think about. I’m not even sure that people who can’t afford insurance have a current notion of what is available in community health.”

Kentucky Primary Care Association Director Smith, along with Dr. Schuster and other advocates of reform, suggested that more “out-stationing” of Medicaid eligibility workers and more delegation of eligibility determination responsibilities, which is permissible under federal law, would open the process and increase the ranks of the insured. As noted in Chapter 2, a significant number of Kentuckians are eligible for but not covered by Medicaid. Moreover, consumer education is often left out of policy implementation, given short shrift, or poorly executed, Dr. Schuster and others suggested.

**Finding the Revenue.** Finnegan believes that health care or health insurance reform in Kentucky came in response to citizen demand. “I think that the message was, ‘We think that we all should have access to care,’ . . . and I think they’re right. But once you say that, you have a concurrent responsibility to fund it.” But this isn’t, in Finnegan’s opinion, an insurmountable problem. “Everybody’s worried about the cost. The cost is not the issue because if you catch it [health care] on the front end . . . it’s going to take 10 or 15 years, but the costs will start to flatten out. You’re



going to have a blip because you're going to have people coming into the system that have never had care . . . but that's manageable."

Dr. Calico agreed. "The financial issues will be resolvable . . . in an environment in which we really are focusing on . . . improving health. We don't do that. We spend almost no resources at all on improving the health of the population. We spend enormous resources on procedures, tertiary-level interventions, that essentially make no impact on the health of the population." Inclusion, he added, is the fundamental issue. "That doesn't mean everybody has to be insured. I don't even think insurance is a part of the answer. It's a part of the problem, not a part of the solution."

Sen. Shaughnessy viewed the new revenue stream being created by the tobacco settlement as an opportunity to address health care needs—if sufficient support can be mustered for making it the focus of new spending. Depending on future cigarette sales, Kentucky could receive as much as \$3.5 billion over the next 25 years as part of the Phase I agreement, beginning in 2000. Already, however, tobacco farmers, who began receiving annual payments over a period of 12 years as part of Phase II settlement in 1999, have seized the political momentum to advocate using settlement funds for development and diversification of the state's agricultural economy.

A noteworthy optimist, Finnegan observed that the structure, administration, and delivery of services are a far more complicated issue than financing a fully inclusive system of health care. That, he believes, is within our reach. A universal, statewide levy, he suggested, would likely be "pretty palatable." A logical target for taxation, he added, is Kentucky's long-protected tobacco industry: "You could raise every penny you need by putting 15 cents on a pack of cigarettes." Similarly, when asked how we pay for universal access to health care, Dr. Peters observed, "It's an issue of fiscal responsibility. We pay for it the same way we're paying for state police." The issues, Dr. Peters observed, are matters of meeting human need economically. "It might take 10 years to do it, but if we don't start now, we'll be having the same conversation in the year 2010, except a lot of people's lives and quality of life will have been lost in the process."

*Dr. Ken Peters*

**Bottom-Up Solutions.** Dr. Calico and many others believe that our current system is, in many ways, illogical. Constrained by habits of mind, we seldom "think out of the box," as management gurus suggest, and thus problems go unresolved, even ignored. Some health care leaders suggest that solutions to the problem of access to health care and its corollary, cost, may best be wrought at the local level. "Health care starts at the community level . . . if our policy could focus on developing functional community-level health care systems," Dr. Calico suggested, "we might then begin to grow a larger system as those functional community units develop and link with each other." Such a bottom-up approach, Dr. Calico and Kepferle believe, offers the hope of discovering workable, if incremental and evolutionary, solutions.

Several of the health care leaders agreed with the concept, stating that, while it may be necessary to establish some new parameters for health insurance at the national level, health care is ultimately a local issue. Paraphrasing former U.S. Speaker of the House Tip O'Neill, Dr. Costich asserted, "All health care is local. I don't think you can talk about a national solution to health care simply because the delivery system is local. You can't have a California-style delivery system in Kentucky or for that matter in some parts of California." Finnegan echoed the same sentiment. "The average practice in the country is still less than six physicians. It's a cottage industry. We tend to look at it as a monolithic industry, but it's really not, and their long-term thinking is 'What's the appointment book like for the next two weeks?' Medicine is a local issue, a community issue."

"It's an issue of fiscal responsibility. We pay for it [health care] the same way we're paying for state police. It might take 10 years to do it, but if we don't start now, we'll be having the same conversation in the year 2010, except a lot of people's lives and quality of life will have been lost in the process."

From Dr. Calico's perspective, community in the truest sense of the word could ultimately rebuild our health care system. He expressed the belief that the full engagement of a continuum of providers in and out of the traditional health care system, what he termed "true care management as opposed to managed care," offers real solutions to problems with the current system. Were we willing to fashion such a system, Dr. Calico suggested, "I don't think you have a clue of how much we could drive down the total consumption of health care." Through Community-Initiated Decision Making, a process that engages the residents of a community in assessing its health care system, planning for improvements, and executing strategies for change, Dr. Calico and Kepferle have witnessed significant improvements at the local level. While these efforts have been partly aimed at encouraging more utilization of the local health care infrastructure, namely hospitals, they also have resulted in more responsive and higher quality services. In Harlan County, a model of health promotion emerged from the process in the form of a citizen-driven exercise program.

As reform advocate Seckel noted, "We've gone a long way from managed care as a community-based cooperative endeavor. Maybe we should look at what were the elements [that] worked and try to build that into our future system."

## Conclusion

Clearly, the inextricably linked issues of cost and access to health care will not be easily resolved. Moreover, state health policy is limited in its ability to influence access, cost, and quality of health care. Some of our most distinguished health care leaders, however, see real opportunities ahead to, among other things:

- bring new vision to health and health care through long-range planning, research, and the implementation of proven strategies in the Commonwealth;
- finance expanded access, public health initiatives, and medical research with tobacco settlement monies and/or targeted revenue streams;
- focus on critically important population health;
- negotiate lower costs and, in turn, broaden access by making the state, with its considerable clout in the insurance marketplace, a more prudent purchaser;
- formulate innovative approaches to public health policy and financing.

In every arena, ample opportunity exists to learn and benefit from the experiences of other states, regions, communities, and private entities that have adopted successful strategies for expanding access, controlling costs, and ultimately improving health outcomes.

Moreover, improving the health of the people of the Commonwealth is our foremost priority, prevention and wellness must be accorded a new level of importance. Indeed, the poor health that is so evident in our state suggests that prevention should be the principal focus of our investments in health care. Over time, promoting good health and preventing or minimizing chronic health conditions may prove to be our best insurance against escalating costs and unresolved limitations on access.

## CHAPTER 5

# What Works: Private and Public Initiatives to Improve Access to Health Services

In this chapter, we examine structural responses to gaps in health care for the uninsured and underinsured and discuss some of the successful programs that have emerged in other states and localities. Broadly speaking, there are two types of initiatives to extend health care access to low-income Americans: subsidies for health services (either financial, in public sector programs, or in-kind, through voluntary and charitable efforts) and expansions of health insurance coverage. The following discussion focuses primarily on the health insurance strategy, but this focus is not intended to understate the importance of direct services, particularly for the most vulnerable Americans. We do not anticipate further coverage expansion initiatives from the federal government in the immediate future, and thus focus on alternative responses at the state level.

Which Kentuckians lack access to necessary health services? A recent study by the UK Center for Health Services Management and Research reinforced the well-documented link between health insurance and access to services, particularly for adults, and found that the uninsured are more likely to be poor, poorly educated, and rural Kentuckians than their insured counterparts.<sup>82</sup> Some uninsured Kentuckians are actually eligible for coverage: 1997 survey analysis by the Kentucky Legislative Research Commission found that some 123,000 Kentucky children who were uninsured would qualify for enrollment in either Medicaid or the new Kentucky Children's Health Insurance Program.<sup>83</sup> Extensive studies have demonstrated that Americans without health insurance are far less likely than their insured neighbors to receive preventive care, early intervention for chronic conditions, and even lifesaving treatment.<sup>84</sup>

## Insurance Regulation and Government Sponsorship

Legislation that mandates broader health insurance availability has been enacted in most states during the 1990s. Statutes typically have the effect of requiring commercial insurance purchasers to cross-subsidize those who were previously excluded from coverage because of health or employment status.<sup>85</sup> While premiums for these health plans may be slightly lower for those who were charged more because of their poor health, it is clear that the price reduction this strategy yields does not suffice to extend coverage to the large majority of those who are currently uninsured.<sup>86</sup> Insurance market reform alone cannot succeed in extending coverage to low-income Americans.

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<sup>82</sup> Scutchfield, Beaulieu, and Lomax.

<sup>83</sup> Kentucky Legislative Research Commission, Research Memorandum No. 480, Jan. 1998.

<sup>84</sup> S.H. Zuvekas and R.M. Weinick, "Changes in Access to Care, 1977-1996: The Role of Health Insurance," *Health Services Research* 34.1 (1999, Part II): 271-80; J.Z. Ayanian, "The Relation Between Health Insurance Coverage and Clinical Outcomes Among Women With Breast Cancer," *New England Journal of Medicine* 326 (1993): 326-31; P.D. Sorlie, "Mortality in the Uninsured Compared with that in Persons with Public and Private Health Insurance," *JAMA* 154 (1994): 2409-16.

<sup>85</sup> Frank Sloan and Christopher Conover, "Effects of State Reform on Health Insurance Coverage of Adults," *Inquiry* 35 (Fall 1998): 280-93; Zuckerman and Rajan.

<sup>86</sup> Richard Kronick and Todd Gilmer, "Explaining the Decline in Health Insurance Coverage, 1979-1995," *Health Affairs* 18.1 (1999): 30-47.

Affordability is a critical issue for families with limited resources who face premium costs that often exceed \$5,000 per year for even a modest policy. For those with income levels above Medicaid eligibility but below 200 percent of the federal poverty level (FPL; see Table 1), coverage is likely to be affordable only with a subsidy. This premise is illustrated by the federal standards for the Children's Health Insurance Program, which allow states to offer free or heavily subsidized coverage to families up to 200 percent of the FPL. The question then becomes how, and to whom, this health insurance subsidy will be provided.

Several options are available to add to the pool of funding for low-income uninsured Kentuckians. Some of these have been tested in various forms. For example:

- *managed care*: the use of cost-containment mechanisms to generate savings for coverage expansion,
- *time-limited General Assistance*: state- or locally-funded support for targeted residents,
- *local tax-supported initiatives*: other community-based programs, generally supported by property taxation,
- *limited-benefit policies*: insurance policies with statutory exemption from benefit mandates in exchange for tight restrictions on marketing,
- *vouchers*: certificates that can be exchanged for specific subsidized services,
- *donated services*, in the honored tradition of the health professions, and
- *Medicaid expansions*, discussed at greater length in this chapter.

Other proposals currently being considered nationally or regionally, such as tax credits or deductions, have yet to be implemented and can be evaluated only hypothetically.

Even programs that are available without the payment of premiums do not reach all eligible persons: Medicaid only attracts about 80 percent of eligible persons, and this figure has remained quite stable for years.<sup>87</sup> The whole concept of insurance requires a degree of social integration and stability that some Americans have difficulty maintaining or consciously reject, and even universal access to coverage will never translate into universal coverage in the absence of stringent (and unpalatable) mandates.

## Assessing the Options

The effectiveness of initiatives designed to expand access to health care is often difficult to determine. Consequently, in our evaluation of initiatives from other states, we used a number of criteria that we believe are important considerations in determining whether an initiative is indeed exemplary. Many programs that are too new for definitive evaluation may yield transferable ideas and innovations in the years to come. The criteria we considered were:

- *the policy objective*: was the program enacted to expand Medicaid eligibility generally, to reach targeted populations, to maximize use of federal matching funds, or to support vulnerable providers?
- *the demographics*: is the level of enrollment attributable to the composition of the local population, the proportion of working-age or senior citizens, or alternative subsidized program availability?
- *the eligibility criteria of the program*: for example, some are limited to children, families, the recently unemployed, or small business employees;

TABLE 1 Federal Poverty Levels by Family Size	
Family Size	Yearly Pre-tax Income
1	\$8,240
2	11,060
3	13,880
4	16,700
5	19,520
6	22,340
7	25,160
8	27,980

<sup>87</sup> Liska, Brennan and Bruen.

- *the longevity of the program*: a recent study suggests that a plan must be in place for at least three years before its effects can be assessed meaningfully;<sup>88</sup>
- *the effect of the program on the cost of health care*, both as an element of the state budget and across the range of policies and programs.

Empirical data on program innovations can be elusive. As a distinguished investigator has remarked, such programs “are extremely complex, and experience often is not reported in the literature, especially on a timely basis and with sufficient operational detail to explain how state programs, in fact, work.”<sup>89</sup>

In the following sections, we survey state strategies using Medicaid, state funding, combinations of Medicaid and state-only revenues, local tax initiatives, innovative types of insurance, and several federal tax options, in addition to creative combinations of public and private support for comprehensive health programs. Economist Sherry Glied notes that different strategies benefit different groups of uninsured persons, and a combination of approaches is probably necessary to achieve equitable access to appropriate health care while keeping costs at a sustainable level.<sup>90</sup>

## Medicaid

Medicaid covers 13.6 percent of Kentuckians,<sup>91</sup> above the national average of about 10 percent in 1998. Because states have broad discretion to set Medicaid eligibility criteria and because of rapid change in Medicaid delivery systems, it is very difficult to make meaningful interstate comparisons of the success of Medicaid strategies. Seventy percent of Medicaid expenditures nationally are attributable to services for aged, blind, and disabled persons, although adults and children in low-income families account for nearly three fourths of Medicaid beneficiaries.<sup>92</sup> Medicaid’s complex eligibility policy, which “both states and the federal government have relied on ... as a tool for limiting their financial exposure for the cost of covered benefits,” makes the program difficult for its beneficiaries to understand and for the states to administer.<sup>93</sup>

An unexpected side effect of the massive (42 percent since 1994) decline in welfare caseloads has been a significant downturn in the number of people seeking Medicaid coverage nationally. Program administrators attribute this decline to the requirement that eligible persons apply separately for Medicaid, rather than being enrolled automatically as part of a broader eligibility determination process, because of the new time-limited cash assistance rules.<sup>94</sup> However, most employed former welfare recipients do not receive health care coverage through their employers and are unlikely to be able to afford it without subsidy.<sup>95</sup>

### Medicaid Demonstration Waivers and Managed Medicaid

The removal of burdensome Medicaid waiver requirements under the Balanced Budget Act of 1997 accelerated the pace of managed Medicaid development. Over half of Medicaid enrollees are now in some form of managed care plan.<sup>96</sup> Many states look to managed care to help contain Medicaid costs and provide funds for coverage expansions to previously ineligible residents. A

<sup>88</sup> Hing and Jensen, note 51.

<sup>89</sup> Marsha Gold, “Making Medicaid Managed Care Research Relevant,” *Health Services Research* 33.6 (1999): 1639-50.

<sup>90</sup> Sherry Glied, Report: An Assessment of Strategies for Expanding Health Insurance Coverage. Washington, DC: Henry J. Kaiser Family Foundation, Oct. 1999, online at: [www.kff.org](http://www.kff.org).

<sup>91</sup> Personal communication, Kentucky Department for Medicaid Services, 14 Oct. 1999.

<sup>92</sup> John Iglehart, “The American Health Care System: Medicaid,” *New England Journal of Medicine* 340.5 (1999): 403-08.

<sup>93</sup> Andy Schneider, Kristen Fennel, and Peter Long, *Issue Paper: Medicaid Eligibility for Families and Children*, Washington, DC: Henry J. Kaiser Family Foundation, Sept. 1998.

<sup>94</sup> Smith et al., note 42.

<sup>95</sup> Smith et al.

<sup>96</sup> “Medicaid Statistics,” Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services, Baltimore, Maryland, online at: [www.hcfa.gov](http://www.hcfa.gov), Oct. 1999.

less “managed” form of managed care, the Primary Care Case Management (PCCM) model<sup>97</sup> familiar to Kentuckians as KenPAC, is used exclusively in Arkansas and appears in other states, as in Kentucky, where managed Medicaid has not yet been implemented. The proportion of Medicaid eligibles in managed care varies from 13.6 percent in Illinois to 100 percent in Tennessee, depending on legislative mandates and the state’s experience with managed care. Sudden moves to universal managed care in states such as Tennessee and New York have been far more disruptive than in Oregon and Minnesota, with their long histories and broad enrollment in commercial managed care plans.

Eleven Medicaid demonstration projects expand eligibility in highly variable ways: Vermont has increased eligibility to 150 percent of the FPL, Hawaii’s limit is 300 percent of the FPL, and in Tennessee, all uninsured persons were eligible for Medicaid at varying contribution rates, regardless of income until an enrollment cap was reached.<sup>98</sup> California and New Jersey have implemented Medicaid demonstration projects to supplement revenues for safety net providers such as public hospitals and health department clinics. Florida subsidizes commercial insurance premiums for low-income employed persons with non-Medicaid funds; a similar Oregon plan is discussed at greater length below.

Although the state of Washington’s Medicaid waiver program was only recently approved by the Health Care Financing Administration, the state has been working through a major health care reform effort for the past decade. Washington’s Basic Health Plan (BHP) subsidizes health insurance coverage from participating plans. Sliding scale subsidies are available up to 200 percent of the FPL, and those with higher incomes can join by paying the full premium. Employers can purchase coverage for employees through the BHP, but few have chosen to participate.<sup>99</sup>

When looking to other states’ experiences with Medicaid managed care for guidance in Kentucky, it is important to remember that the Regional Partnership system in this state is unique. A recent summary of extensive research into Medicaid managed care across the nation suggests the following observations about Kentucky’s managed Medicaid:

- Most states limit Medicaid managed care to children and younger adults rather than including elderly and disabled enrollees who participate in Medicare as well. This approach simplifies implementation but limits potential savings. The inherent difficulty in meshing managed Medicaid with nonmanaged Medicare plans for persons enrolled in both Medicare and Medicaid portends serious problems with Kentucky’s integration of these Medicaid beneficiaries into managed care plans.
- Many states, like Kentucky, are finding that managed care savings are modest because traditionally low Medicaid fee-for-service payment rates make it difficult for states to squeeze capitation levels or for HMOs to negotiate further discounts. The dramatic increase in prescription drug utilization has also overtaken projected savings.
- Safety net providers—public hospitals, community health centers, primary care and rural health providers, and clinics operated through local health departments—that need Medicaid revenues to survive have received special allocations from many states. These payments have helped to preserve the fiscal status of these providers, but the additional cost reduces potential Medicaid savings.<sup>100</sup> The effect of managed Medicaid on safety net providers was well documented before Kentucky’s Regional Partnerships were implemented.

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<sup>97</sup> Under the Primary Care Case Management system, Medicaid enrollees other than the aged, blind or disabled are assigned to primary care physicians who are responsible for coordinating their care and approving referrals, emergency department visits, and other special services.

<sup>98</sup> 1.3 million persons (initially set at 1.4 million), over 400,000 of whom are new Medicaid eligibles.

<sup>99</sup> Shruti Rajan, “Publicly Subsidized Health Insurance: A Typology of State Approaches,” *Health Affairs* 18.2 (1998): 101-117.

<sup>100</sup> Robert Cunningham, “CHCs’ Loss of Medicaid Stealth Subsidy Jeopardizes Uninsured,” *Medicine & Health* 29 July 1996.

- The combination of low capitation rates and protections for safety net providers has limited the willingness of commercial HMOs to enter into Medicaid managed care contracts in some states. There may be a tradeoff between expansion of access to providers in the private sector and maintenance of safety net providers.<sup>101</sup> In light of recent history, Kentucky's decision to set up separate Medicaid HMOs with regional monopolies may have been prescient because it avoids the volatility of other states' interactions with commercial HMOs.
- Managed care implementation has been slow and difficult in rural areas because of providers' resistance, lack of commercial managed care activity, and an inadequate supply of providers. Other states have attempted to cope by modifying contracting strategies, travel time standards, 24-hour coverage requirements, and primary care case management requirements to adapt programs to the realities of rural environments.<sup>102</sup>

## Non-Medicaid State-Subsidized Coverage

In 30 states, General Assistance (GA) programs provide cash and in-kind resources to low-income persons for limited periods when they are ineligible for other federally funded assistance. In some areas, part of this funding is allocated for health benefits. These programs are financed and administered entirely by the state, county, or locality in which they operate.<sup>103</sup> Jefferson County is the only jurisdiction in Kentucky that provides any GA, and the Jefferson County program does not include health care benefits. Income eligibility limits vary, but most programs limit assistance to those with income below half the poverty level. Because the income and resource limits are so stringent and because eligibility is typically time-limited, no state's enrollment in GA programs exceeds 15 percent of enrollment in the state's regular cash assistance program. A comprehensive survey of GA and related programs by the Urban Institute found that states with broad-based state-sponsored programs had uninsurance rates for low-income persons that were 30 percent lower than those in states with limited programs. However, GA programs do not give childless adults without access to employer-sponsored coverage a stable source of health care coverage.

## Combining Medicaid with State-Sponsored Programs

Several states have added their own programs to Medicaid to extend coverage to specific categories of uninsured residents. Generally, these programs have focused on the temporarily unemployed, the elderly (to supplement prescription drug coverage), children (before the implementation of the state-federal CHIP initiative), and those with incomes just above the cutoff for Medicaid eligibility.<sup>104</sup>

### Massachusetts

Massachusetts funds several programs for low-income residents in addition to its Medicaid waiver for managed care.<sup>105</sup> MassHealth, as the programs are known collectively, is a comprehensive health insurance premium assistance program for parents, children, senior citizens, and pe r-

<sup>101</sup> John Holahan, Joshua Wiener, and S. Wallin, *Health Policy for the Low-income Population: Major Findings from the 'Assessing the New Federalism' Case Studies*. Occasional paper no. 18. Washington, DC: Urban Institute, 1998.

<sup>102</sup> R.T. Slifkin, S.D. Hoag, P. Silberman, S. Felt-Lisk, and B. Popkin, "Medicaid Managed Care Programs in Rural Areas: A Fifty-state Overview," *Health Affairs* 17.6 (1998): 217-27.

<sup>103</sup> L. Gallagher, C. Uccello and H. McCallum, *State General Assistance Programs, 1998*. Washington DC: The Urban Institute, 1998.

<sup>104</sup> For an in-depth survey of these programs, see Laura Summer, *State-Subsidized Health Insurance Programs for Low Income Residents: Program Structure, Administration, and Costs*, American Academy on Aging/Commonwealth Fund, April 1998, online at: [www.cmf.org/programs/insurance](http://www.cmf.org/programs/insurance).

<sup>105</sup> See the HCFA website at: [www.hcfa.gov/medicaid/mafact](http://www.hcfa.gov/medicaid/mafact), or the Commonwealth of Massachusetts website at: [www.state.ma.us](http://www.state.ma.us).

sons who are disabled or unemployed. Coverage in MassHealth is provided under contract with eight managed care plans, and, as in many other areas, managed care offerings in rural areas are quite limited.

In addition to the Massachusetts Children's Health Insurance Program, a pre-CHIP Children's Medical Security Plan gives children access to health insurance coverage for primary and preventive health care. Another program called the Medical Security Plan provides health insurance for people collecting unemployment benefits. The Insurance Partnership helps qualified small employers and the self-employed pay for health insurance provided to their employees under age 65 whose incomes are low enough to make them eligible for MassHealth. The Insurance Partnership reduces eligible employers' premiums for qualified employees by up to 30 percent.

Apart from the usual Medicaid funding, MassHealth is funded by a statewide tobacco tax and modest premiums for children in families with income between 150 percent and 200 percent of the FPL. Special financial protections augment the funding stream for safety net providers by bringing their net revenue to a level that approximates the pre-managed care revenue under cost-based reimbursement.

We may well question what Kentucky can learn from Massachusetts because of the profound historical, socioeconomic, and demographic differences between the two states. The relevance of Massachusetts programs is primarily that they have been in place for long enough for meaningful evaluation, and to a lesser extent, that several programs are specifically tailored for subsets of uninsured residents. It is also worth noting that managed care is a relatively recent, and rather controversial, phenomenon in Massachusetts, as in Kentucky.

### Minnesota

Nearly one in four Minnesotans is enrolled in Medicare or another publicly sponsored program, a fact that largely accounts for the state's very low uninsurance rate.<sup>106</sup> MinnesotaCare was created in 1992 as a sliding-scale, subsidized health insurance program for low- and moderate-income people who do not have access to other health insurance coverage. Funding for MinnesotaCare, apart from a modest Medicaid allocation, comes from a provider tax and premiums. Kentucky readers will doubtless be aware that provider taxes have been very unpopular here.

Families with children are eligible for MinnesotaCare at income levels below 275 percent of the FPL. Adults without children are eligible up to 175 percent of the FPL. An applicant must have been uninsured for at least 4 months, and must have had no access to employer-subsidized insurance coverage for at least 18 months, with limited exceptions. About 105,000 people (2.1 percent of the state population) were enrolled in MinnesotaCare at the end of 1998. Parents and children make up 89 percent of enrollees, and three quarters of enrollees have family incomes below 150 percent of the FPL; over 90 percent have family income under 200 percent of the FPL.

Very small and declining numbers of Minnesotans who are ineligible for Medicaid are enrolled in the state-funded General Assistance program (0.7 percent of population) and the state's high-risk pool (0.6 percent of population). As in Kentucky, funding for the excess of costs over premium revenue for high-risk pool enrollees is through an assessment on state-regulated plans, but the growth of self-insured plans exempt from state regulation had decreased the revenue from this source to such an extent that the 1997 Minnesota legislature appropriated \$15 million to the high-risk pool for 1998 and 1999 to assist in covering losses.

An interesting byproduct of Minnesota's high rate of insurance coverage is the decline in the state's overall rate of uncompensated care. The state's hospitals now spend an average of only 2.8 percent of their total expenditures on uncompensated care, compared with a national average of 6.1 percent.<sup>107</sup>

As with Massachusetts, Kentucky can learn from Minnesota despite the obvious differences in demographics and Minnesota's longstanding tradition of investment in the health of its residents.

<sup>106</sup> "Health Care Coverage and Financing in Minnesota: Public Sector Programs," Health Economics Program, Minnesota Department of Health website at: [www.health.state.mn.us](http://www.health.state.mn.us), Mar. 1999.

<sup>107</sup> *Id.*



Diverse funding streams—state and federal tax dollars, provider taxes, health plan assessments, and excise taxes—support both general programs for low-income residents and groups of specific concern, such as families with children and persons with potentially high-cost health conditions. The very low rate of uninsured Minnesotans has clear costs as well as benefits, but these are costs the state's citizenry appears willing to bear. Unlike Kentucky, Minnesota has a very competitive, well-established managed care market that covers all but the most rural areas, and a population well oriented to managed care may be another factor in the success of Minnesota's programs.

### Oregon

Oregon's unique approach to expanding state-subsidized health coverage was enacted in 1989 and implemented in 1994.<sup>108</sup> Citizen groups and experts meet periodically to decide which services should be covered under the plan, raising and lowering the standard to match funding. This explicit rationing of services has resulted in a list of covered benefits that is at least as generous as standard Medicaid packages in other states. Oregon's reforms have reduced the percentage of uninsured residents from 18 percent in 1990 to 11 percent in 1997. As of early 1999, 684,700 Oregonians participated in the plans.

While cost containment was one goal of the state legislature, reimbursement rates were intended to be adequate to avoid the pervasive practice of cost shifting that led providers to increase charges for non-Medicaid patients to cover inadequacies in Medicaid reimbursement. Research into the financial impact of Oregon's unique structure suggests that the rationing process accounts for no more than 2 percent of program cost savings over the first five years of the program, while three times as much has been saved through the use of managed care plans. In addition to the usual state-federal Medicaid funding stream, Oregon's coverage expansions have been funded by part of a state cigarette tax.

Oregon's health care initiatives, collectively known as the Oregon Health Plan (OHP), include a Medicaid Demonstration; the Oregon Medical Insurance Pool, a high-risk pool; the Insurance Pool Governing Board, an individual and small business purchasing cooperative; Small Employer Health Insurance reforms; the Family Health Insurance Assistance Program, a subsidized program described below; and the Children's Health Insurance Program.<sup>109</sup> More than 80 percent of all Oregon Health Plan participants are enrolled with a managed care plan, but the number and geographic range of the plans have shrunk significantly, and there is little if any choice of plan in rural Oregon.<sup>110</sup> Nearly all licensed physicians in the state participate in the Medicaid program, along with more than half of the state's dentists.

The most unusual of the OHP plans is the Family Health Insurance Assistance Program,<sup>111</sup> which subsidizes low-income (under 170 percent FPL) uninsured Oregonians' purchases of commercial health insurance on an income-related sliding scale.<sup>112</sup> Employees receive direct subsidies for employer-sponsored or state-certified insurers in the form of checks that arrive before the payment is due or the payroll deduction occurs. Despite the hypothetical appeal of such a program, only 3 percent of uninsured Oregonians with incomes below 170 percent of the FPL participated

<sup>108</sup> Lawrence Jacobs, Theodore Marmor, and J. Oberlander, "The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did," *Journal of Health Politics, Policy & Law* 24.1 (1999): 147-80; Thomas Bodenheimer, "The Oregon Health Plan—Lessons for the Nation," *New England Journal of Medicine* 337.9 (1997): 651-55; 337.10 (1997): 720-23.

<sup>109</sup> The Medicaid Demonstration covered 50.0 percent (including 82,000 newly eligible), SEHI covered 44.8 percent, IPGB covered 2.6 percent, CHIP covered 1.5 percent, OMIP covered 0.8 percent and FHIAP covered 0.3 percent. Assessment of the Oregon Health Plan Medicaid Demonstration, Oregon Department of Administrative Services, online, Office for Oregon Health Plan Policy and Research Web site, online at: [www.ohppr.state.or.us](http://www.ohppr.state.or.us)

<sup>110</sup> *American Health Line* "Oregon Health Plan: Backing off HMOs in Rural Areas," 28 Apr. 1999. The state's response has been to allow groups of doctors unaffiliated with hospitals or insurers to manage patient care for office visits, X-rays and lab work on a partially capitated basis, with the state paying for hospital and drug costs on a fee-for-service basis.

<sup>111</sup> Oregon Revised Statutes 653.805 (1).

<sup>112</sup> Office for Oregon Health Plan Policy and Research, "Evaluation of the Family Health Insurance Assistance Program, Jul. 1, 1998-Jun. 30, 1999," Salem, Oregon.

in the program in early 1999, and almost 90 percent of participants had incomes at or below 150 percent of the FPL.

The OHP must fight for adequate funding in each legislature, and there appears to be a general sense that it is too expensive in its current form. The 1999-2001 Oregon budget proposals included \$80 million reduction request from the governor and a further \$48 million cut recommended by Republican legislators.<sup>113</sup> Oregon's legislature has made specific appropriations to help public hospitals and other safety net providers continue their service to uninsured and underinsured persons.<sup>114</sup>

Health policy analysts watched the development of the Oregon plan with great interest because of its uniquely public decisionmaking process. An important lesson for Kentucky policymakers is the need for adequate reimbursement to support wide provider participation as the proportion of providers' revenue that depends on publicly funded plans grows. The perspective of Oregon's physician-governor is doubtless influential in the maintenance of this provider-friendly program feature. Publicly funded plans in many cases pay less than the actual cost of providing a given service, so providers' ability to participate in these plans depends on the extent to which revenue shortfalls can be made up from other funding sources. If publicly funded patients represent a large majority of a practice or facility's revenue stream, the provider will find it difficult to survive financially.

### Rhode Island

Rhode Island provides expanded health care coverage to low-income children and pregnant women up to 250 percent of the FPL through RItCare, its Medicaid program.<sup>115</sup> In November 1998, RItCare expanded parents' eligibility to 185 percent of the FPL using state funding and eliminated the limits on assets that characterize most Medicaid coverage for adults. As with most publicly funded coverage expansions, persons who already have health insurance are not allowed to drop it voluntarily and enroll in RItCare.

RItCare increased enrollment by 12,000 in the first six months of 1999, for a total of 86,000 enrollees.<sup>116</sup> The governor's ultimate goal is to eliminate uninsurance in Rhode Island; over the balance of 1999, he hopes that RItCare will add another 13,000 to its rolls.

RItCare is administered through contracts with managed care organizations that also serve commercial members. Reimbursements to health care providers—a common source of trouble in such plans—are being supplemented through a \$1.2 million increase in health plan funding over 18 months. RItCare has increased enrollee access by requiring health care providers to take RItCare enrollees if they want to care for commercial members of a participating HMO. Private and public agencies perform outreach and enrollment functions and receive a small fee for enrolled applicants.

Rhode Island's population is only one fourth of Kentucky's, so a much smaller improvement in its insured population translates to a higher percentage change. The significant lesson from Rhode Island's recent success in expanding public coverage is the pivotal role of the governor. By making health care coverage for low-income residents a primary goal of his administration, he appears to have found the funding and political will to overcome the usual budgetary and political obstacles.

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<sup>113</sup> Penelope Lemov, "Critical Condition," *Governing* Oct. 1999: 22-27; *American Health Line*, "Dental Coverage: Proposed or Drop 'Expensive Savings,'" 22 June 1999.

<sup>114</sup> Bodenheimer, note 27.

<sup>115</sup> Jocelyn Guyer and Cindy Mann, "A New Opportunity to Provide Health Care Coverage for New York's Low-Income Families," The Center on Budget and Policy Priorities, Washington, DC, July 1999.

<sup>116</sup> F. J. Freyer, "Rhode Island's Uninsured Enroll in Managed Care Program," *Providence Journal-Bulletin* 21 July 1999, online, Nexis.

## Tennessee

Our neighbors in Tennessee have both positive and negative lessons for us. They have suffered provider rebellion, consumer confusion, enrollment caps, and management turmoil since their TennCare program was implemented in January 1994. Despite its rocky start, the program has succeeded in lowering Tennessee's uninsurance rate significantly.<sup>117</sup> Its long-term viability, however, is a frequent concern; in September 1999, yet another TennCare director resigned. Tennessee's experience must be accounted for in any analysis of public health care funding, but whether its expansion of coverage will ultimately be found to justify its human and financial toll remains to be seen.

TennCare enrollment at the end of June 1999 was approximately 1,312,969, of which 814,181 were in Medicaid programs and 498,788 were either previously uninsured or had been rejected by insurance carriers. Enrollment has been closed and reopened to various groups over the past four years, but the program has been open continuously for low-income children, dislocated workers, and those who have been denied commercial coverage because of their health. TennCare eliminated deductibles and limited copayments for these newly eligible populations and all uninsured children who had previously enrolled in TennCare.

Enrollment is financed by pooling current federal, state and local expenditures for indigent health care, including Medicaid and hospitals' identified pre-TennCare indigent care load. Of the program's total 1999 budget of \$3.779 billion, \$1.418 billion funds long-term care programs, Home and Community-Based Services Waiver programs, Medicare crossovers through the Medicaid system, Medicare premiums, and administration for the total program.

The state's cost-containment goal is a TennCare budget that grows at a predictable rate no greater than the overall rate of growth in state spending.<sup>118</sup> However, this goal does not appear to be achievable in the current TennCare environment. One of the most serious concerns about TennCare is the solvency of its participating managed care organizations, several of which have either gone into receivership or been the subject of solvency alerts.<sup>119</sup> In early 1999, the legislature pumped an additional \$190 million in state dollars, to be matched with \$380 million in federal dollars, into the 1999-2000 TennCare budget, increasing it to nearly \$4.3 billion next year.<sup>120</sup>

An insurance system whose survival is constantly threatened heightens the anxiety that leads Americans to seek insurance in the first place. While TennCare has succeeded in the short term by reducing the number of uninsured Tennesseans, newspaper accounts frequently report its impending collapse. Tension between budgetary demands and escalating health care costs are amplified when such a large proportion (nearly one in four) of the population is covered through a public program.

## Wisconsin

Wisconsin is often held up as a model of health care access, boasting an uninsurance rate that is about half the national average.<sup>121</sup> State initiatives are only part of the picture: a strong economy, a healthy population, and a very high rate of employer-sponsored coverage are important factors. The program highlighted here is only a small part of the state's public health insurance initiatives, but its innovative design will bear watching in the future.

Wisconsin implemented BadgerCare in July 1999 to provide health care coverage to families (both parents and children) with incomes under 185 percent of the FPL. Enrolled families can keep their coverage up to 200 percent of the FPL. The state uses Medicaid funds to cover parents in

<sup>117</sup> David M. Mirvis, Cyril F. Chang, Christopher J. Hall, Gregory T. Zaar, William B. Applegate, "TennCare—Health System Reform for Tennessee," *Journal of American Medical Association* 247 (1995): 1235-1241; Lemov, supra.

<sup>118</sup> State of Tennessee website at: [www.state.tn.us/health/tenncare](http://www.state.tn.us/health/tenncare).

<sup>119</sup> D. Cheek, "State to Devise Backup Plan for Troubled TennCare," *The Tennessean* 13 Aug. 1999, online at: [www.tennessean.com/sii/99/08/13/gov13.s](http://www.tennessean.com/sii/99/08/13/gov13.s).

<sup>120</sup> B. Snyder, "TennCare Boost Just Buys Time," *The Tennessean* 31 May 1999.

<sup>121</sup> Teresa Coughlin, Joshua Weiner, Jill Marsteller et al., *Health Policy for Low-Income People in Wisconsin* (Washington, DC: Urban Institute, Jan. 1999) online at: [www.urban.org](http://www.urban.org).

BadgerCare families and Children's Health Insurance Program (CHIP) funding for newly eligible children.

Wisconsin initially sought to use CHIP dollars for parental coverage, but the stringent federal limits on CHIP for adults resulted in repeated HCFA rejection of state proposals. The state then opted to use the Medicaid waiver process for parental coverage funding. The flexibility of the waiver system allowed Wisconsin to charge premiums for families with incomes above 150 percent of the FPL and exclude individuals with access to affordable employer-based coverage.

The waiver also addresses concerns that using Medicaid as the vehicle for financing the program could create a fiscal burden on the state. If spending exceeds budgeted targets, eligibility will be restricted, although current enrollees will be allowed to remain in BadgerCare even if they exceed the lowered income guidelines.

Wisconsin's broad, stable base of insured residents probably facilitates the precise, targeted policymaking of which BadgerCare is an example. As in the case of its innovative welfare-to-work policy, we may question whether what works in Wisconsin will work in Kentucky or elsewhere in the absence of a similar breadth and stability of employer-sponsored coverage.

### Summary

Creative combinations of Medicaid expansions and state-supported programs obviously require legislative endorsement of supplemental funding (in addition to normal Medicaid budgeting) and careful balancing of expanded entitlements with fiscal constraints. Despite their diversity, these state approaches have some common features:

- Now that the CHIP programs expand children's eligibility, state programs focus on other members of low-income families, low-income workers, and those whose health status is an impediment to coverage;
- Budgetary flexibility is built in through provisions that lower income-based eligibility levels when necessary to avoid funding shortfalls (Oregon is unique in adjusting benefits);
- Managed care systems are used in most areas, although many rural areas are administered through more traditional financing systems;
- Staged implementation is more palatable than TennCare-style instant changeovers, but either requires careful planning to avoid incentives for providers to cost-shift and consumers to drop commercial insurance coverage (a phenomenon known as "crowd-out");
- State funding beyond Medicaid requirements is perpetually subject to renegotiation at each new legislative session.

## Local Initiatives

Community-level initiatives exemplify the "bottom-up strategies" that are advocated by several health care leaders we interviewed. On a smaller scale than the statewide initiatives just described, local programs make important strides in closing gaps in access to health care. The first two initiatives described in the following section are Ford Foundation/Kennedy School of Government Award winners and have been cited as models for the Bureau of Primary Health Care's new campaign to promote access and eliminate socioeconomic disparities in health.

### Hillsborough County, Florida

Public and private sector representatives in the greater Tampa area have created a nationally celebrated model by pooling assets from the community's share of state appropriations, community provider resources, and local tax revenue to subsidize health services for low-income residents without health insurance.<sup>122</sup> In 1991, after the Hillsborough County Commission petitioned

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<sup>122</sup> Patricia Bean, "Think Globally, Act Locally: Expanding Access to the Uninsured," Presentation to National Academy for State Health Policy, 2 Aug. 1999.

the Florida legislature for local taxing authority, the county was authorized to impose a 0.5 percent sales tax (later reduced to 0.25 percent) to fund uncompensated health care. A recent report by the Deputy County Commissioner indicated that 70 percent of the target population (up to 100 percent of the federal poverty level) had been enrolled at some point during the seven years of the program.<sup>123</sup> The plan also offers coverage to persons rejected from commercial insurance plans due to health status, and a supplementary benefit for low-income enrollees in Medicare or a military-related health plan. The mean monthly cost per enrollee has been reduced from \$233 to approximately \$200. It is important to note that maternity benefits are not included because pregnant women at the target income eligibility level are eligible for Florida's Medicaid program.

The Hillsborough County plan is particularly noteworthy for its ability to mobilize and coordinate community resources in the ongoing development and monitoring of its programs. With a local population rapidly approaching one million and a large tourist industry that employs many low-income workers, the county appears to have had both an acute enough problem to motivate action and a resource base adequate to meet the need.

### Buncombe County, North Carolina

Buncombe County, where Asheville, North Carolina, is located, has used its indigent care funds to coordinate public and private groups in order to provide comprehensive health services to 13,000 of the county's estimated 15,000 uninsured persons.<sup>124</sup> The Buncombe County Medical Society Project Access links the local health department, Medicaid agency, and medical society, along with hospitals, indigent care clinics, and pharmacies. Some 500 physicians and dentists participate and are recognized by having their names published regularly in the local newspaper.

The local medical society is under contract with the county to provide program oversight, volunteer recruitment, coordination and tracking of referrals and services, and management of pharmacy assistance. Physicians donate their services; hospitals donate laboratory, radiology, and nursing services; pharmacists donate their dispensing fees; and the county funds the cost of bulk medications. Uninsured low-income patients reach these services through a primary care provider at private physician offices, health departments, or other community-based medical clinics. North Carolina's governor has promoted the replication of the Project Access structure in eight other counties.<sup>125</sup>

## Other Exemplars

The following programs are also winners or runners-up in the Bureau of Primary Health Care's "Models That Work" Program. They were selected because they represent comprehensive approaches to health services for their target populations and, like the Tampa and Asheville models, involve both public and private partners.

### HealthLink, Lakes Region General Hospital, Laconia, NH

**Services:** Preventive, primary and specialty care, mental health, inpatient, and prescription drug services.

**Target Population:** Uninsured, unemployed residents not eligible for public assistance.

<sup>123</sup> Another assessment suggests that this figure exaggerates the plan's success because only about 14,000, or 35 percent of the target group, have been enrolled at any given time. Kalkines, Arky, Zall & Berstein LLP, *The Health Care Safety Net: A Report of the Financially Distressed and Voluntary SLIPA Hospitals* (New York: Author, January 1999).

<sup>124</sup> "BCMS Project Access, Innovations in American Government Program, 1998 Winner," online at: [www.ksg.harvard.edu/innovations/winners/bcmsnc98](http://www.ksg.harvard.edu/innovations/winners/bcmsnc98), 31 Aug. 1999.

<sup>125</sup> John Boyle, "Award-Winning Buncombe Health Care Project on Track to Become Model for N.C., Nation," *Asheville Citizen-Times* 19 May 1999: B1.

*Partners:* 91 local health care providers; the Lakes Region General Hospital (enrollment, case management and a portion of prescription costs); Blue Cross Blue Shield of New Hampshire (actuarial and claims processing services); and 11 pharmacies (offering prescription drugs at Medicaid rates).

Access to Care Program, Suburban Primary Health Care Council, Westchester, IL

*Services:* Primary care physician and other low-cost office visits, laboratory and radiologic testing, and discount prescription medication. Volunteer physicians specify the number of patients they can take and receive some compensation.

*Target Population:* Uninsured, low-income residents in suburban Cook County. The program has discounted contracts for other services from hospital, laboratory, radiology, and pharmacy partners.

*Partners:* Northwest Suburban Cook County Health Care Task Force, Park Forest Health Department, Community and Economic Development Association of Cook County, and Cook County Department of Public Health.

Health Access, Network & Development, Oak Hill Community Medical Center, Oak Hill, OH

*Services:* Nursing, dental, pharmacy, medical supplies, teleradiography, tuberculosis control, non-emergency medical transportation, patient education and resources, and counseling by a dietitian.

*Target Population:* Indigent, elderly, disabled, underinsured, and uninsured area residents.

*Partners:* Oak Hill Community Medical Center, Jackson County Health Department, Jackson County Rural Health Clinic, Jackson County Board of Aging, Inc., Jackson-Vinton Community Action.

Medical Home Project, American Academy of Pediatrics, Arizona Chapter

*Services:* Physician services, diagnostic procedures and prescriptions up to \$500 per patient.

*Target Population:* Underserved, uninsured children of low-income families identified by school nurses in over 40 school districts.

*Partners:* Over 100 pediatricians, family physicians, nurse practitioners and specialists, statewide laboratory and prescription services, Arizona Department of Health Services, foundation funding, modest patient fees.

Pediatric Primary Care Project, Prince William Area, Manassas, VA

*Services:* Comprehensive primary health care and support services.

*Target Population:* Children of the underserved, uninsured working poor.

*Partners:* Virginia Health Care Foundation, Potomac Mills, Prince William Health District, volunteer pediatricians, Kaiser Permanente, local universities and businesses.

Importantly, the Tampa and Asheville models have several features in common with these award-winning initiatives that suggest approaches for Kentucky communities:

- consensus identification of underserved target population and health care needs;
- broad-based community support, particularly among physicians and other health care providers;
- cooperation among public agencies, physicians, civic organizations, hospitals, businesses, and other stakeholders in the health of the community;
- combination of public and private funding in addition to donated services;
- identification of roles and contributions for each partner;
- public acknowledgment of participants' contributions; and
- inclusion of consumers in planning and evaluation processes.

### Home-State Initiatives

In the Commonwealth, Health Kentucky and Kentucky Physicians Care exemplify the types of provider organizations that have made many programs across the country into sustainable vehicles for comprehensive service to low-income members of their communities. These Kentucky organizations served as the model for an entire foundation-funded program earlier in the decade because their appeal and effectiveness are so compelling. If communities are to take charge of their uncompensated care problems, however, it is unrealistic to expect private health care providers to bear the entire burden. The missing pieces here have been: cooperation and coordination with local health departments, primary care centers, hospitals, other health care providers (e.g., imaging centers, clinical laboratories, prescription drug vendors), businesses and civic organizations. The challenge is to mobilize the wealth of available resources towards common goals, creating a synergy that is greater than the sum of its parts.

## Tax-Based Approaches

Several proposals to expand health insurance access use the federal income tax structure to create incentives, for example, by

- increasing the deductibility of health insurance premiums for individual purchasers;
- providing tax credits for low-income health insurance purchasers; or
- building on the Earned Income Credit process.<sup>126</sup>

The likely success of these proposals in bringing down the rate of uninsurance will depend on factors such as:

- the adequacy of the tax credit offered;
- the ability of low-income workers to leverage the credit into premium payments at the time they are due; and
- the type of commercial insurance policy available for purchase with the tax credit-generated funds.

Workers who currently have income tax withheld from their paychecks may be able to adjust their withholding and eliminate end-of-the-year reconciliation, but managing these adjustments is an added complication for families and may reduce willingness to participate. For many low-income employees, wages vary significantly from season to season or week to week, making the use of tax incentives even more problematic. Many others have no tax obligation at all, so even a fully refundable credit does not give them cash for premiums in the months before the refund check arrives.

Another structural issue for strategies to provide low-income uninsured persons with funds to purchase policies on their own is the high cost and instability of the individual market, particularly in Kentucky.<sup>127</sup> The theoretical appeal of individual choice encounters grim reality in many smaller insurance markets like Kentucky's where only one or two carriers offer individual policies. This phenomenon is acknowledged in a recent proposal by Senator Pete Stark (D-CA) that would establish a separate insurance pool for these purchases and require insurer participation as a condition of offering coverage to federal employees.

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<sup>126</sup> "Health Insurance Plans: A Summary," *The National Journal* 31.29 (1999); John Shiels, Paul Hogan, and Randall Haught, "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy," Washington, DC: National Coalition on Health Care, 18 Oct. 1999, online at: [www.nchc.org](http://www.nchc.org).

<sup>127</sup> See Chapter 2, *supra*. Deborah J. Chollet and Adele M. Kirk, *Understanding Individual Health Insurance Markets* (Washington, DC: Henry J. Kaiser Family Foundation, March 1998).



## High-Risk Pools

Over half the states, including Kentucky, have high-risk health insurance pools.<sup>128</sup> These arrangements are intended to allow people to buy commercial health insurance despite health conditions that would lead insurers to reject their applications (in the absence of mandatory guaranteed issue). Premiums are partially subsidized but are typically 25 percent to 50 percent higher than the average for persons of the same age and place of residence. It is important to note that without a high-risk pool, some of these individuals would be impoverished by uninsured health care costs to such an extent that they would qualify for Medicaid. Risk pools normally cover a very small fraction of any state's insured population for two reasons: enrollment is often capped, and premiums are high enough to be prohibitive for lower income uninsured persons.

A high-risk pool obviously does not solve the problem of the uninsured: high-risk enrollees were recently found to range between 0.3 percent and 8.23 percent of the total number of uninsured persons, depending on the state in question.<sup>129</sup> A recent study suggests that the presence of a high-risk pool that does not have an enrollment cap adds about one percent to the rolls of the privately insured and over time, decreases Medicaid enrollment by 1.3 percent.<sup>130</sup>

Because of the small number of enrollees in any state, global surveys are unlikely to unearth information about high-risk pool enrollees. However, research suggests that having this kind of mechanism to take potentially high-cost persons out of the regular insurance market "may enable insurers to worry less about adverse selection and thereby price lower in the individual market, which could increase private coverage."<sup>131</sup> Another investigator who interviewed officials in Wisconsin and Indiana found that risk pools helped small businesses contain insurance costs by avoiding a significant global premium increase when one employee was diagnosed with a high cost condition.<sup>132</sup> While this effect may be helpful for small businesses with a small number of high-risk employees, premiums for other employers and employees are slightly higher when insurers pass on the cost of the assessments that subsidize high-risk enrollee premiums. Conversely, to the extent that high-risk pools cover high cost cases that would otherwise be uncompensated, having a pool may lower costs for insured persons by eliminating some of the cost shifting that providers would otherwise have to use to support uncompensated care.

Kentucky's high-risk pool, known as the Guaranteed Acceptance Plan (GAP), is too new to have been included in any of these studies. The success of the GAP in shoring up Kentucky's fragile individual insurance market will be followed with interest by many observers. As is so often the case, there is a critical need for data and informed analysis in this area, both within the Commonwealth and across the country.

<sup>128</sup> Communicating for Agriculture, *Comprehensive Health Insurance for High-Risk Individuals* (Minneapolis, MN: Author, 1998).

<sup>129</sup> Sally C. Stearns, Rebecca T. Slifkin, Kenneth E. Thorpe, and Thomas A. Mroz. "The Structure and Experience of State Risk Pools: 1988-1994," *Medical Care Research and Review* 54.2 (June 1997): 223-238; B. Sumner, Bryan Dowd, A.M. Pheley, Nicole Lurie, "Denial of Health Insurance Due To Preexisting Conditions: How Well Does One High-Risk Pool Work?" *Medical Care Research Review* 54.3 (1997): 357-71.

<sup>130</sup> Jill Marsteller, Len Nichols, Adam Badawi et al., *Variations in the Uninsured: State and County Level Analyses* (Washington, DC: Urban Institute, 1998) online at: [www.urban.org](http://www.urban.org).

<sup>131</sup> Id.

<sup>132</sup> Susan S. Laudicina, "State Health Risk Pools: Insuring the 'Uninsurable,'" *Health Affairs* 7 (Fall 1988): 94-104.

## Medical Savings Accounts and Other High-Deductible/Limited-Benefit Plans

Medical savings accounts (MSAs) were a popular approach to expanding health insurance coverage in the mid-1990s, although the very low sales of these policies since their authorization by the 1996 Congress suggests that both supporters' enthusiasm and opponents' fears may have been misplaced.<sup>133</sup> MSA legislation allows self-employed and small group purchasers of high-deductible policies to tax shelter out-of-pocket costs (with limited employer contributions). Several states have mirrored federal tax exemptions for MSAs.

The underlying philosophy of MSAs is that comprehensive insurance leads to overutilization because coverage makes the insured person insensitive to the costs incurred for unnecessary care. Because the MSA enrollee would have to pay routine health costs out of pocket, he or she has a clear incentive to be a more prudent purchaser of essential services.

A number of arguments have been raised regarding the propensity of MSAs to attract the relatively healthy and wealthy, leaving others to make the non-MSA insurance market less favorable and thus more expensive. Most workers are healthy and thus would gain financially by switching to MSAs from traditional insurance. This adverse selection would raise costs, and therefore premiums, for those who chose to remain with non-MSA plans.

To date, the number of enrollees in MSAs has been so small that their market impact is likely negligible. Congressional MSA advocates have proposed changes that would make them more appealing, such as opening enrollment to larger employee groups, lowering the minimum family deductible from \$3,000 to \$2,000, and allowing employees to tax shelter the full deductible amount, rather than the current 65 percent or 75 percent.<sup>134</sup>

Low-cost, "bare bones" health insurance plans have been authorized in some 31 states. Generally, the statutes establish closely regulated sales options in exchange for exemption from certain state-mandated benefits.<sup>135</sup> Their effect on increasing the number of insured persons nationally has been insignificant, despite the well-documented tendency of mandated benefits to increase the rate of uninsurance.

## State Prescription Drug Plans for Medicare Enrollees

The cost of prescription drugs for Medicare enrollees has been a growing national concern because of the relatively high premiums and limited drug benefits of Medicare supplement ("Medigap") policies. Medicaid covers drug costs for the very poorest Medicare enrollees, but Medicaid income and asset tests are so stringent for senior citizens that only the truly indigent qualify. Proposals to address this problem at the federal level appear to have died for the current congressional term, but will doubtless re-emerge in 2000. In much of the country, Medicare HMOs offer some drug coverage, but Kentucky has thus far seen very limited Medicare HMO activity. The escalating cost of prescription drugs has led many Medicare HMOs in other parts of the country to restrict or drop generous drug coverage.

<sup>133</sup> Janet Gemignani, "What's Holding Back MSAs?" *Business & Health* Nov. 1997: 34-39; Greg Scandlen, "Why MSAs Are So Slow to Catch On," *Consumers' Research Magazine* 81.9 (1998): 21-25; Emmett B. Keeler, Jesse D. Malkin, Dana P. Goldman, Joan L. Buchanan, "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *JAMA* 275 (1996): 1666-1671; L. Ozanne, "How Will Medical Savings Accounts Affect Medical Spending?" *Inquiry* 33.3 (1996): 225-36; Marilyn Moon, Len Nichols, and Susan Wall, *Medical Savings Accounts: A Policy Analysis*, Washington, DC: Urban Institute, March 1996, online at: [www.urban.org/pubs/hinsure](http://www.urban.org/pubs/hinsure).

<sup>134</sup> *American Health Line*, "Medical Savings Accounts: GOP Senators for Program Expansion," 10 May 1999.

<sup>135</sup> Sloan & Conover, *supra* note 4. Although the applicability of their findings to Kentucky is impossible to determine, it is noteworthy that the only state health policies for which they find statistically significant positive effects on the likelihood of persons being insured are Medicaid expansion (which moves some people into Medicaid) and purchasing alliances (which move some people from publicly-funded to commercial coverage). Abolishing age rating for the 55-64 age group increased their likelihood of having commercial coverage. See also Patricia A. Butler, "Flesh or Bones? Early Experiences of State Limited Benefit Health Insurance Laws," Presented to National Academy for State Health Policy, Aug. 1992.

At least 14 states provide prescription drug assistance to low-income residents on Medicare; about 700,000 people received benefits under these plans in 1997.<sup>136</sup> Most have very low (under \$12,000 per year) income eligibility levels, although New York and New Jersey set eligibility at over \$18,000. All require a modicum of enrollee cost sharing, either in the form of copayments, enrollment fees, or deductibles. While the primary target population is low-income seniors, several states have parallel plans for persons enrolled in Medicare because of disability. Some limit coverage to specific drugs or therapeutic categories, and Maine requires the drug manufacturer to agree to a rebate arrangement in order to have a specific drug covered. Several states have annual coverage limits; Massachusetts, for example, only covers up to \$750, but the computation is based on the state's heavily discounted purchase price. State prescription drug assistance plans are funded by general revenue, lottery proceeds, and casino gambling revenues (New Jersey).

## Maintaining the Safety Net

Regardless of the changes Kentucky makes in insurance funding for low-income Kentuckians, some will still need services outside a public or private insurance system. Even universal health insurance coverage will not eliminate the need for safety net providers: community health departments and other clinical centers, hospital-based services that are open when most other health care sources are closed, and public hospitals themselves.

Subsidized or charitable health services are extended to uninsured Americans in myriad programs spanning the public and private sectors. Examples of government subsidies for health services (as opposed to health insurance) include block grants for services to pregnant women, children, and persons with specific diseases or conditions, the Disproportionate Share Hospital payments to facilities that serve Medicaid enrollees, programs for migrant workers, homeless persons, and the developmentally disabled. The charitable provision of health services takes place informally throughout the health care sector, but its more visible and organized manifestations include free clinics, free or reduced-price drugs, medical society voluntary programs such as Kentucky Physicians Care, and targeted outreach programs at schools, health fairs, and other public gathering places.

The need to maintain adequate publicly funded services is particularly obvious for children because they often cannot reach necessary health services without an adult's assistance. An evaluation of three pre-CHIP Medicaid expansions for children showed that while extending health insurance to low-income children affected their access positively, insurance alone did not result in more appropriate use of preventive services and emergency departments. Important variables in access to care included the availability of a convenient "medical home" with after-hours services, continuity of enrollment, and support services.<sup>137</sup> Thus, even with health insurance, these children needed the safety net for adequate care.

Medicaid managed care has predictable and well-documented effects on safety net providers such as community health centers, health department clinical services, and hospitals with large low-income service populations. Some states that have implemented Medicaid managed care appear to have reduced provider reimbursement to an extent that limits resources available to cross-subsidize care for the medically indigent.<sup>138</sup> A recent multistate study (not including Kentucky) concluded that access to care for low-income uninsured persons is lower in states where a higher proportion of Medicaid enrollees were in managed care plans. This finding should not surprise anyone familiar with the budgetary goal of Medicaid managed care. When less money is allocated

<sup>136</sup> David Gross and Sharon Bee, *State Pharmacy Assistance Programs* (Washington, DC: AARP, April 1999) online at: [www.aarp.org/health](http://www.aarp.org/health).

<sup>137</sup> M. L. Rosenbach, C. Irvin, and R.F. Coulam, "Access for Low-Income Children: Is Health Insurance Enough?" *Pediatrics* 103 (1999): 1167-74.

<sup>138</sup> Peter J. Cunningham, "Pressures on Safety Net Access: The Level of Managed Care Penetration and Uninsurance Rate in a Community," *Health Services Research* 34.1 (Part II) (1999): 255-270.

for services to low-income people, either directly through Medicaid or in a combination of Medicaid and subsidies to safety net providers, fewer services can be provided.<sup>139</sup>

A policy question that can be addressed constructively is the extent to which safety net providers should be asked to compete with their counterparts in the private sector for state-funded enrollees and state funds in general. If Kentucky values the services that safety net providers offer to uninsured and underinsured Kentuckians, the cost of these services can be identified and accounted for. Declining to provide adequate funding sends a clear message that the fiscal viability of safety net providers is not a priority for the state. The recent shortfalls for health department-based primary care services in Kentucky graphically illustrate the extent to which these clinics depend on reimbursement beyond normal managed care payment rates to finance indigent care.

## Getting Back to Cost

Many of the health sector leaders interviewed for this report put the cost of health care or health insurance at the top of their list of concerns. Their view is shared by the majority of Americans: the 1999 Health Confidence Survey conducted by the nonpartisan Employee Benefit Research Institute found that 89 percent of those surveyed thought that making health care more affordable should be a major goal of U.S. health care reform.<sup>140</sup> The survey also found that the cost of health insurance is the major reason why most people lack health care coverage: 77 percent of the uninsured cited cost as the major reason for not having health insurance.

One reason why the cost of insurance, rather than the cost of health services, attracts such attention is that few Kentuckians pay the full cost of health services (with the exception of prescription drugs for many Medicare beneficiaries). As Representatives DeWeese and Damron note, there is no prospect for any short-term decrease in the cost of health insurance. National trends suggest that year-to-year increases may approach 10 percent in the next few years.<sup>141</sup> Kentucky's Commissioner of Insurance and his staff carefully monitor insurer price increases, but most premiums appear to be justified by dramatic increases in pharmacy cost and utilization, expensive new technologies, and consumer demand for expanded choice of health care providers. If the narrow financial edge on which most Kentucky insurers now claim to operate reflects reality, policymakers must turn to the provider sector and consumer demand for answers.

Cost-cutting initiatives run into one indisputable fact: one person's cost is another person's revenue or service,<sup>142</sup> and if the person receiving the revenue or service is valued by policymakers, that person's interests are likely to be protected. Careful planning may help avoid unwanted consequences of cost cutting, such as the bankruptcies of health care groups and termination of home health services that are currently emerging. Yet attempts to curb unmanageable increases in health care costs often seem to be an exercise in balloon squeezing: shrinkage in one area immediately results in expansion elsewhere.<sup>143</sup> Ironically, the congressional debates over HMO regulation and Medicare funding include repeated pleas for higher rather than lower allocations of both public and private funding for health care.

<sup>139</sup> Thomas R. Oliver, "The Collision of Economics and Politics in Medicaid Managed Care: Reflections on the Course of Reform in Maryland," *Milbank Memorial Fund Quarterly* 76.1 (1998): 59-101.

<sup>140</sup> Employee Benefits Research Institute, Issue Brief #492, Washington, DC, 1999.

<sup>141</sup> *American Health Line*, "Employers Brace Themselves for Spiraling Premiums," 21 Sept. 1999; "Rate Hikes, Higher Costs Force Employers to Fight Back," 17 Aug. 1999; "Florida Inches Closer to Rate Hike Deal: Regulatory Response to Medicare Supplemental Policy Premium Increase Requests as High as 50%," 23 June 1999.

<sup>142</sup> Christine E. Bishop, "Health Cost Containment: What It Will Mean for Workers and Local Economies?" *Public Health Reports* 114 (May-June 1998): 204-213.

<sup>143</sup> Alan B. Cohen, "Hitting the Target in Health Care Cost Control," *Journal of Health Politics, Policy & Law* 24.4 (1999): 697-703; see also Joseph White, "Targets and Systems of Health Care Cost Control," *Journal of Health Politics, Policy & Law* 24.4 (1999): 653-96.

There are many strategies to contain health costs at the provider level, such as

- reducing the unit cost of services (as with Medicare's fees for some physician specialists);
- reducing the volume of services (such as therapist visits or inpatient hospital days);
- substituting less expensive caregivers or materials;
- limiting services to the most remunerative types of diagnoses or patients;
- increasing staff workloads;
- automating labor-intensive functions; or
- closing services that attract low-income patients.

The past decade has seen widespread health care mergers, acquisitions, and spinoffs. When internal cost-containment strategies reach their limits, health care providers look for more dramatic solutions: closing entire facilities, selling assets, bankruptcy or receivership. Many of these activities are rational responses to the need to contain costs, but it is important to recognize the price each exacts, both in human terms and in their effect on the availability of health services.

The quest for health care cost containment leads policymakers to look to the insurance sector to manage provider costs and its own administrative load as efficiently as possible. In light of recent Kentucky history, the imposition (or reimposition) of more stringent statutory restrictions on health insurance carriers raises obvious concerns. As Representatives Damron and Burch both note, the ability of states to contain costs by regulating insurance is very limited, and comprehensive action can only occur at the federal level.

The August 1999 takeover of an Owensboro-based provider-sponsored HMO by the Kentucky Commissioner of Insurance is a local manifestation of the deep financial problems encountered by many such organizations.<sup>144</sup> On average, Kentucky managed care plans have spent between 85 percent and 90 percent of their revenues on medical benefits in each of the past four years. While this rate of medical spending far exceeds the classic fee-for-service carriers' historical trends of 70 percent to 75 percent, it is not unlike spending rates for other states. Illinois, for example, recently reported an 89.7 percent medical spending ratio for its managed care plans. Forty-five of the nation's 55 Blue Cross & Blue Shield plans had costs for member services and administration that exceeded their premium revenues, but most (34) made up for these deficits with income from investments and securities. Likewise, in the health insurance sector as a whole, \$835 million in losses was more than made up for with over \$2 billion in investment income and gains on the sale of investments.<sup>145</sup> Industry analysts and observers such as Dr. Holsinger question how long insurers can continue to eat into their capital portfolios to make up for operational losses.<sup>146</sup>

The federal government's attempt to move the risk of insuring Medicare and Medicaid beneficiaries into the private sector by contracting with HMOs has been under way for the past two years with limited success. Kentucky has seen very little Medicare managed care activity, and thus has not experienced the turbulent market shifts occurring in other states. Kentucky's Medicaid managed care is unique in its system of provider-based Medicaid-only regional plans, but other states that have relied on the commercial insurance market to serve Medicaid clients have seen many carriers leave in the past two years.<sup>147</sup>

<sup>144</sup> *American Health Line*, "Dallas Doctors' Group Files for Bankruptcy," 28 July 1999; "Doctor Groups: Unihealth to Sell Its Six Units in CA," 15 Sept. 1999; "California: MD Financial Crisis Looms Over System," 8 Sept. 8, 1999; "Physician Owners: Face Hurdles in Launching Products," 11 Aug. 1999; "Doctors' Health Plans: Physicians Launch HMO Alternatives," 24 Feb. 1999.

<sup>145</sup> "Four Out of Five Blue Cross Blue Shield Plans Losing Money In Their Underwriting," *Business Wire* 19 Aug. 1999.

<sup>146</sup> The current year's financial picture is even bleaker in some areas. New Hampshire operations of several large New England health plans recently reported net losses for the year to date, and the Insurance Commissioner in Wisconsin reported that 15 of the 24 Wisconsin HMOs posted net losses in the second quarter of 1999. Illinois HMOs lost \$71.1 million in 1998, with average medical expenses at 89.5 percent of premium revenues. The Texas Department of Insurance reported that state's HMOs had their fourteenth straight quarter of losses during the March-June period. *American Health Line* 7 Sept. 1999.

<sup>147</sup> See, e.g., Federal Document Clearing House "Medicare Families in HMOs Are at Risk of Losing Benefits" and "Gore Calls for Norwood-Dingell Patients' Bill of Rights and Medicare Expansion to Cover Prescription Drugs," 22 Sept. 1999;

Would restrictions on the business organization of health insurers help contain cost? For-profit insurers are vulnerable to charges of excessive executive compensation and attention to profits at the expense of members' well-being. Tax laws restrain not-for-profit insurers' activities, and their tax advantages open them to both a higher level of scrutiny and demands that they provide benefits commensurate with the value of their tax exemption. From an economic perspective, it is unlikely that any regulation of health plan compensation structures or community benefit requirements would generate savings sufficient to offset the relentless cost pressure of pharmacy costs, the health care requirements of our aging population, and growing consumer demand for convenient, state-of-the-art care.

## Conclusion

The shortest route to reducing the uninsured population of other states has been the creative use of Medicaid and other state and locally funded health benefits. Obviously, these are also the strategies that require the most difficult legislative decisions. Variations in the economic and political climate in states that have chosen this approach have led to frequent changes in eligibility criteria, covered benefits, and implementation schedules. Depending on the analyst's perspective, the dynamic quality of these plans may reflect either a negative instability or a positive flexibility. In any case, precise targeting of state subsidies requires timely and accurate data about population health, health care costs, and insurance coverage, all of which are seriously lacking in Kentucky.

State and regional variations in health care organization and delivery systems also influence the structure and outcome of health care initiatives. Oregon had a 40-year history of managed care before implementing its unique approach to Medicaid expansion. In contrast, managed care was quite unfamiliar in Tennessee in 1994, when its entire Medicaid delivery system was suddenly transformed to a managed care system, with widely publicized difficulties.

The first issue in any expansion of state funding for low-income citizens is always cost. A global view of the cost of uninsurance in addition to the cost of state subsidies may bring budgetary implications into clearer focus. Uncompensated services are a major burden for hospitals, physicians, primary care clinics, and all other health care providers. Again, large gaps in Kentucky's health information infrastructure impede accurate analysis.

Apart from their constant exposure to the winds of political change, state-sponsored coverage expansions must be carefully structured to facilitate input from health care providers in both design and implementation. Physicians and dentists who willingly provide uncompensated care to low-income patients often decline to participate in government-sponsored programs for the same people when the programs treat them as adversaries rather than collaborators in caregiving.

The inclusive, collaborative nature of successful community-sponsored health plans is both cause and effect of their popularity. They are essential health resources, but they are also important sources of civic pride. However, it is important to assess these plans in their historical and political contexts. What works in some states and localities may not work in others for a variety of reasons. Some successful initiatives are responses to legal requirements (the analogy in Kentucky would be the Kentucky Education Reform Act that responded to a judicial mandate). Hillsborough County, Florida, like many localities across the country, developed its prizewinning health plan partly to satisfy a state mandate to provide for its medically indigent population. In Kentucky, only Louisville has a similar legal obligation.

Other notable successes are the culmination of decades of work. Asheville, North Carolina built its comprehensive, multifaceted approach to care for uninsured residents on a long-standing tradition of community-based outreach and philanthropic involvement. The more urban areas of Kentucky have some well-established voluntary and charitable clinical service sites, but rural areas often have too few health care providers to eke out any philanthropic surplus.

Kentucky is facing a difficult policy-balancing act, as enunciated by the state's health policy leaders in their interviews, between competing priorities:

- maintaining a reasonable degree of stability in the commercial insurance market;
- containing cost; and
- reducing the number of uninsured persons and the concomitant burden of uncompensated care.

In order to solve these tough problems, state policymakers can explore approaches to:

- define local and state accountability in a manner that suppresses the endless round of cost-shifting;
- identify and pool existing and potential indigent care resources;
- identify areas of predictable unmet need;
- foster collaborative initiatives that acknowledge providers, consumers, and funders; and
- support these inquiries with a broad-based, timely and responsive health data infrastructure. ➔



## CHAPTER 6

# Prescriptions for Change

Whether we blame the growing disparities in access to health care on too much government interference or social injustice, the bottom line remains the same. Limitations on access to health care in the United States are exacting significant economic and social costs. Ultimately, these costs are borne by all of us. While we are keenly aware of costs such as higher health insurance copayments and premiums, the larger costs of inadequate access to health services are subtle and quietly destructive. Poor access to health care can rob people of their ability to work, nurture their families, and participate in their communities. For children, unattended medical needs can interfere with critical learning and socialization processes and even result in long-term disability or premature death. These social costs, as much as the cost of uncompensated health services, spread throughout our economic and health care systems where we all absorb them. Thus, in spite of the frustrations of recent efforts, the costly consequences of a substantial uninsured population compel us to continue pursuing answers to the dilemma of health care access. Indeed, closing the widening gaps in access to health care becomes more important with each passing year.

As the leaders interviewed for this report consistently observed, cost has become a significant obstacle to creating a more inclusive system. High health care costs are pushing more and more people into the ranks of the uninsured and threatening the long-term viability of publicly financed health insurance programs. In the private sector, more employers are offering health insurance in today's tight labor market, but a smaller proportion of eligible workers are taking advantage of this important benefit. In the public sector, health care is consuming an ever-larger portion of revenues and thus exacting higher tax burdens.

Current trends suggest that the cost of health care will continue rising inexorably. While some argue that we have wrung virtually all the excess cost out of health care, many of the health care leaders we interviewed here believe that much more can be done to control health care costs. Learning more about the root causes of these costs and altering the behaviors of consumers, providers, and payers will become increasingly important as our aging population exerts new pressures on the health care system.

The philosophical origins of our increasing share of gross domestic product spent on health care are coming under increased scrutiny. One prominent social philosopher, Theodore Roszak, suggests in his new book, *America the Wise*,<sup>148</sup> that increased spending on health care to improve quality of life and extend longevity is a worthy societal goal. Rather than being a cause of alarm, Roszak predicts that the worth of these services will ultimately compel our society to realign its values, devalue the materialism that drives our consumer economy, and invest more generously in the intangible but enriching contributions of older citizens. Within the current framework, however, resource limitations appear to be on a collision course with demographic change. Ensuring the wise use of our resources will continue to be an overriding societal goal, one that will only become more important as we invest more and more in the health and well-being of older citizens.

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<sup>148</sup> Theodore Roszak, *America the Wise* (Oxfordshire, GB: Houghton Mifflin, 1999).



As the health care leaders quoted here strongly assert, avoiding many of the long-term costs of an aging society demands that we reorient our health care priorities, that we place far more value on preventing negative outcomes, rather than intervening after they have occurred. To achieve optimal results, all citizens must be included. We are challenged, in particular, to bring children into a system of care management focused on maintaining health through preventive measures and on education designed to foster positive behavioral and lifestyle choices. In the absence of an inclusive system, the same costly, disproportionately poor health outcomes will persist among the disadvantaged and underserved and continue to exact a substantial cost on society. It is in our best interest to craft an inclusive system that cultivates wellness and avoids many of the costs that threaten to undermine the viability of the U.S. health care system, however flawed it may be.

Though much work remains to be done at the national level to ensure greater parity in health care cost, quality, and access, the Commonwealth can exert significant influence over our health care. Our first step, some of the leaders interviewed here suggested, is reckoning with the very difficult question of our values in regard to health care. Citizens of the Commonwealth continue to express strong support for an inclusive health care system, just as they have for many years. In 1999, they made it their highest priority for the future of our state (see Figure 7). To respond to citizen values, we must begin to set goals and priorities and chart a course of action. The short-term costs may not yield immediate benefits, but preventing needless and costly ill

## FIGURE 7 TAKING THE PUBLIC PULSE

In 1999, the Kentucky Long-Term Policy Research Center and the University of Kentucky Survey Research Center found that health care had become the most important goal for citizens of the Commonwealth. When asked to rank 26 goals in the order of their importance, citizens cited an inclusive health care system as the state's top priority. In 1997, citizens ranked this goal third. Similarly, in 1992, 82.5 percent of respondents to the Kentucky Health Survey agreed that the state should move toward a fully inclusive insurance system that bases premiums on income rather than risk. A majority of 1992 respondents (52.7 percent) said state government should administer such a program, 27.7 said a private firm should, and 19.3 percent said they did not know.<sup>149</sup>

In another 1999 survey, Professors Ellen J. Hahn and Mary Kay Rayens of the University of Kentucky College of Nursing in collaboration with the University of Kentucky Survey Research Center queried citizens of the Commonwealth about whether they would support an increase in Kentucky's tax on cigarettes, which is the second lowest (3 cents per pack) in the nation. The majority of respondents (55.5 percent) said they did not favor an increase in the cigarette tax. Opposition to a cigarette tax, however, was far higher among current smokers, who comprised 30.3 percent of respondents. Among those who reported having smoked in the past month, 83 percent opposed raising the cigarette tax compared to 43 percent of nonsmokers.<sup>150</sup>

In spite of a general aversion to taxes, a significant percentage of the state's population (44.5 percent) favored an increase in the cigarette tax, including 17 percent of current smokers. When asked to choose from six possible levels of tax increases, the majority of those who favored the tax chose the highest possible option, "more than 50 cents per pack." This response was chosen more than twice as often as any of the other five options.<sup>151</sup> Thus, considerable public support exists for added taxes on cigarettes, support that may be stronger if tied directly to closing gaps in access to health care.

<sup>149</sup> The Kentucky Health Survey was conducted by the University of Kentucky Survey Research Center. Households were selected using random-digit dialing, a procedure giving every residential telephone line in Kentucky an equal probability of being called. A total of 617 interviews were completed. The margin of error for the survey was slightly less than 4 percentage points at the 95 percent confidence level.

<sup>150</sup> Ellen J. Hahn, Mary Kay Rayens and the University of Kentucky Survey Research Center, *Fall 1998 Kentucky Survey* 8 Apr. 1999. Calls for the delayed Fall 1998 survey were made between March 4, 1999, and April 6, 1999. A total of 628 interviews were completed. The margin of error for the survey is slightly less than 4 percentage points at the 95 percent confidence level.

<sup>151</sup> Hahn, Rayens and the UK Survey Research Center.

health remains in the best long-term interest of our state. To do so, we must include more people in our system of health care.

Based upon the practical and the visionary observations of the health care leaders interviewed for this report and on our research into state and community exemplars of expanded access, we offer policy recommendations here that, we believe, will improve access to health care as well as all-important health outcomes. Some of these recommendations provide an immediate remedy to limitations on access while others would create the framework for more thoughtful decisionmaking and improved long-term outcomes. Both are worthy and important goals. It is in our long-term interest to begin meeting the needs of those who are not included in our system of health insurance even as we begin to develop a new structure for decisionmaking and improvement of our system. Our recommendations for achieving these goals follow.

## Provide the Tools and Organizations for Informed Decisionmaking

Many of our interview subjects regretted the absence of an informed, unified health policy entity in the Commonwealth. Lack of access to this level of expertise means that health care policy is effectively shaped by representatives of the various interests who gain or lose by policy shifts. While the defunct Health Policy Board was less than optimal by many accounts, the merits of establishing an impartial body or investing an existing group with the authority to act in an influential advisory capacity are considerable. In an arena full of vested interests, a reputable, objective body with either access to reliable data or the resources and authority to collect and analyze data independently could make an enormous contribution to the future of health care in Kentucky. Such an entity could help identify promising approaches to reduced costs, improved quality, and broader access.

Many of the health care leaders whom we interviewed pointed to the inadequacy of state resources devoted to systematic health data collection, analysis, and reporting. As elsewhere in state government, we lack sufficient data for planning, resource allocation, program evaluation, and cost control. Without such information, one of the critical tools for continuous improvement of any system is simply unavailable to us.

Comprehensive regional data that tracks trends in population health, health insurance status, and health care utilization would enable policymakers to make more informed decisions and to respond to changing needs. These data would also help inform the public about health care delivery and, over time, give Kentuckians a framework for cost-effective personal health decisionmaking.

At a minimum, we should restore and, if possible, increase funding to conduct, analyze, and disseminate findings of the annual Kentucky Health Survey to ensure a continuous source of information about core health-related issues. In the absence of such critical information, we have made public policy decisions based upon anecdotes rather than on reliable data. We found widespread agreement on this point. Only carefully collected and analyzed data about inputs and outcomes over time will provide reliable measures of the success of any experiment with public policy. A solid cache of reliable data can help lawmakers better evaluate the anecdotes of constituents and lobbyists and enable citizens to assess policy more objectively.

## Recognize the Limitations of Insurance Reform

However noble and well-intentioned, our efforts to enable access to health care through reform of the state's individual and small group health insurance market have had a negligible effect on the uninsured population. Comprehensive reform was not given sufficient time to prove its worth or its failure. Only now are the data needed to make informed choices beginning to emerge. To link legislative causes with market effects would have required leaving statutes in place for a period of years. Instead, we have created a volatile and uncertain insurance marketplace, with negligible effect on access. Some of our interviewees argued that more Kentuckians have been harmed than helped by reform efforts, in spite of their noble intentions.

Clearly, some high-risk consumers can now purchase health care on the individual market, but at a cost that few can meet. The issue of the cost of health services—the ultimate obstacle to more widespread health insurance coverage—has not yet been addressed coherently at the state or the federal level. Affordability limits access to health insurance for most of Kentucky's uninsured, whether they are poor or have high-risk medical conditions. While it is worthwhile to continue to learn more about the insurance market and to refine our regulatory framework after we have sufficient data in hand, the current state of the health insurance market in Kentucky suggests that the best legislative action for the time being is no action.

## Identify, Expand Resources Dedicated to Health Care

The private and public initiatives described as transferable models in Chapter 5 have a common denominator: dedicated resources. Meaningful expansion of access to health care cannot be achieved by forcing commercial insurance purchasers to shoulder the burden: it requires the infusion of equitably shared contributions. Whether we increase taxes, reallocate existing revenue, or earmark tobacco settlement dollars, additional funds will be needed to expand access to health care. Some of the health policy leaders interviewed for this report maintain that increased tax burdens must be avoided at all cost, while others believe that significant public support already exists for expanding health care coverage with tax dollars. Funding health care, they conclude, is simply a matter of summoning the political will to do what is right.

The essential counterpart to adequate resources is prudent purchasing of health care. The state funds health care for nearly one in five Kentuckians through state-run programs like Medicaid and health insurance for state and school system employees and retirees. Responsible state officials should be supported and, where necessary, given access to additional expertise to assure that current and expanded funding is optimally spent.

While seldom acknowledged, a loosely knit network of providers in the Commonwealth has been helping to close the gap in access to health care for many years. Some are part of recognized organizations like Health Kentucky and Kentucky Physicians Care while others quietly contribute low-cost or free health care. The experiences of other states described in Chapter 5 suggest that this network can become a more effective resource with a modest outlay of public funds to identify available sources of care and make them more readily available to those in need. Communities, counties, and regional entities could be invited to bid for funding to help them locate, coordinate, recruit, and publicize resources in a comprehensive response to unmet need.

We conclude that only citizens of the Commonwealth can answer the central question: "Are we willing to help finance health care for all citizens?" Only an open, informed dialogue will determine where and how Kentuckians want to invest their health care resources. Through community meetings, focus groups, surveys, and other avenues, we can begin to learn what value the public places on access to health care and how much citizens are willing to contribute. State and national surveys strongly suggest that citizens are ready to make the tough decisions we have long avoided.

## Enroll the Currently Medicaid Eligible and Expand Eligibility

Fear of the cost of enrolling all eligible Kentuckians in Medicaid has suppressed promotion of the program, but the long-term costs of deferring care—increased rates of disability and lost productivity—may well exceed the cost of full enrollment. Enrolling eligible children, which has become the focus of intense statewide activities since KCHIP was launched, should provide important lessons on how best to extend benefits to eligible Kentuckians. Particular attention should be paid to ensuring that the Medicaid-eligible parents who lost coverage when they left welfare rolls are again enrolled in the system, as federal law intended them to be. Access to health care is an essential support for these vulnerable new workers, one that can help improve their long-term prospects in the labor force.

Policymakers should also explore ways of making the Medicaid program more accessible and user friendly, and reducing its stigma. Physical and psychological obstacles that discourage participation inhibit access to preventive services and, over time, can cause needless and expensive suffering. While full enrollment must be coupled with thoughtful efforts to contain costs, making Medicaid live up to its potential will likely improve health and economic outcomes across the Commonwealth.

The model state initiatives we profile in Chapter 5 achieved lower uninsured rates principally by expanding Medicaid eligibility—the very strategy that Kentucky expressly sought to avoid both in its insurance reform legislation and the initial plans for the implementation of KCHIP. All the successful initiatives required additional revenue to bring in new populations, and most addressed this need forthrightly by passing a tax and earmarking the revenue for the program expansion. Increased Medicaid participation will create costs that must be recognized and accommodated. However, poor, elderly Kentuckians currently consume the large majority of Medicaid resources, so the per-enrollee cost may be lower when a larger group of relatively healthy families enroll. By enrolling more low-income and working Kentuckians, we can progress toward diminishing the incidence of disease and premature death.

## Focus on Population Health

The health care leaders interviewed for this report strongly advocated a focus on population-based health initiatives to improve the health status of all Kentuckians. To do so, we must invest in the core public health roles that health departments have traditionally filled and marshal both public and private resources in a concerted effort to change health behaviors. Because Kentucky has recently led the nation in adult smoking rates<sup>152</sup> and, not coincidentally, lung cancer mortality rates,<sup>153</sup> and has higher than the national average rates of heart disease and cancer mortality, according to the Centers for Disease Control and Prevention, much work needs to be done.

Both clinicians and public health professionals need to emphasize the value of wise health choices and routine screening, such as mammograms and Pap smears. Rates of health screening, some leaders observe, have been increased by secondary prevention efforts, like Kentucky Homeplace and Mountain Scout, which employed outreach workers to facilitate participation. Creative and effective health choices must also be promoted as a part of the education of young Kentuckians if we are to reverse the poor health status of our state.

Recent survey findings also show significant public support for using the funds from the national settlement with tobacco companies to improve population health through youth smoking prevention and smoking cessation programs. Specifically, when asked on the Fall 1998 Kentucky Survey what purposes they believe funds from “a tobacco settlement” should be used for, 57.6 percent favored using the funds to “prevent youth from using tobacco products” and 67.4 percent favored using them to “help smokers to quit.” While a higher percentage (84.9 percent) of respon-

<sup>152</sup> Kathleen O’Leary Morgan, Scott Morgan and Mark A. Uhlig, eds., *Health Care State Rankings, 1998*, 6<sup>th</sup> ed. (Lawrence, KS: Morgan Quitno, 1998).

<sup>153</sup> National Cancer Institute, “Table XV-18: Lung and Bronchus Cancer (Invasive), Average Annual Age-Adjusted Cancer Mortality Rates by State, 1991-95,” *SEER Cancer Statistics Review, 1973-1995*, Bethesda, MD, online at: [www.nci.gov](http://www.nci.gov).

dents favored using the settlement dollars to “help tobacco farmers diversify,” the question pre-dates the January 1999, Phase II agreement earmarking separate funds for tobacco farmers. Respondents may not have been fully aware of the final terms of the Phase II settlement, as the query refers to only one settlement.

Any strategy that we adopt in the interest of expanding access to our health care system should be carefully and systematically evaluated to determine its effectiveness. Only by testing public policy and revising our approaches to reform as circumstances change can we achieve optimal outcomes and continuous improvement of our state’s system of health care. Reliable, objective analysis of policy requires an institutional framework for more informed decisionmaking.

If we fail to address today’s problems with access to health care, tomorrow’s problems will be even more difficult to resolve. We must acknowledge that change in our health care system—beyond tinkering with the health insurance market—is necessary, and that this change must engage us all. The experiences of other states and locales can be useful guides to positive change. With this knowledge in hand, we can begin testing methods of closing the gaps in access to health care, revising public policy as we learn from our experiments, and working to achieve the goals of expanded access, lower costs, and more uniform quality of care. ➔

